RESPECT–Mil

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CARE FACILITATOR REFERENCE MANUAL

THREE COMPONENT MODEL

For Primary Care Management of Depression and PTSD (Military Version)

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For Psychological Health & Traumatic Brain Injury

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RESPECT–Mil

3CM®
THREE COMPONENT MODEL

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Preface

This manual is intended for use as a resource and guide for RESPECT-Mil Care Facilitators providing support to Soldiers being treated for depression and/or post-traumatic stress disorder (PTSD) through military primary care practices. This manual is specific to the support function of Care Facilitators. A separate manual and training has been developed for primary care clinicians (PCCs). Care Facilitators should access both the PCC manual and training session prior to and in conjunction with this manual. Direct specific training in the care facilitation process will be provided by RESPECT-Mil Center of Excellence program staff.

Background

Behavioral health disorders are common among troops that have returned from war zones. This observation is not new. A report based on health records of Civil War veterans showed lifelong health consequences of combat even among those who escaped traumatic injury. Surveys of U.S. combat units returning from the war in Iraq (Hoge, et al., 2004 and 2006) found that as many as one in four Soldiers met criteria for a behavioral health disorder.

Among this group, less than one in three had received help from a behavioral health or primary care professional. The stigma of having a behavioral health disorder looms large. While 80 percent of these Soldiers recognized that they had a problem, fewer than half were interested in receiving help. The gap between the need for treatment and receiving it deserves urgent attention. This manual provides one step towards closing this gap by providing background needed for Care Facilitators working with PCCs to provide high quality behavioral health care that has a solid evidence base for its effectiveness. Recommendations are consistent with and support application of VA/DoD Clinical Practice Guidelines for both PTSD and depression.

The manual describes the RESPECT-Mil program and how to apply the Three Component Model (3CM®), a systematic primary care approach to the management of depression that has been extensively and successfully used in civilian populations (Oxman, et al.; Dietrich, et al., 2004). A recent project with the 82nd Airborne Division at Fort Bragg expanded the 3CM to address post-traumatic stress disorder (PTSD) as well as depression. The project demonstrated that this approach can be used successfully to provide care for troops post-deployment.

Here is how the Three Component Model works:

- Soldiers attending primary care for sick call and who otherwise have a scheduled visit with a PCC are routinely screened for depression (two questions) and PTSD (four questions);
- Those with positive screens complete appropriate diagnostic and severity instruments before seeing the PCC;
- If the instruments suggest that behavioral health issues require exploration and the PCC's diagnostic interview confirms the diagnosis of depression or PTSD, treatment is initiated by the PCC who will continue to follow the patient closely;
- In addition to primary care follow-up visits, Soldiers in treatment are provided with telephone support from a specially trained RESPECT-Mil Care Facilitator, a registered nurse, who promotes adherence to the management plan and monitors response to treatment using validated quantitative instruments. The Care Facilitator communicates routinely and staffs cases with a Behavioral Health Specialist (BH Specialist) who will

provide management suggestions communicated in reports from the Care Facilitator to the PCC. The BH Specialist is usually a psychiatrist because of the current primary care treatment focus on psychotropic medications. The BH Specialist also assists in linking a Soldier to a behavioral health provider when indicated or requested;

- Thus, a partnership with the patient is shared among the PCC, a Care Facilitator, and a Behavioral Health Specialist.

This manual describes the RESPECT-Mil conceptual framework and its application first to depression and then to PTSD. For both conditions, use of validated instruments for screening and for symptom assessment are central as are the services of a Care Facilitator, frequent primary care contact, promotion of self-management, and modification of the management plan, if needed, to achieve improvement in symptoms.

SECTION I:
THE THREE COMPONENT MODEL & RESPECT-Mil

The elements of the 3CM for management of major depressive disorder and PTSD treatment are not unique, but rather the product of a wide range of recent research and dissemination activity. The essential components of this model, known as 3CM®, include prepared PCCs and practices, the Care Facilitator, and a BH Specialist all working in partnership with the patient.

Recently the investigators who created the 3CM have collaborated with the Department of Defense's Deployment Health Clinical Center (DHCC) and the Henry M. Jackson Foundation (HMJF) to bring this model of care to the Army in the Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) program. In early 2005, a RESPECT-Mil pilot was initiated at the Roscoe Robinson Health Clinic (RRHC) of Womack Army Medical Center at Fort Bragg, North Carolina, resulting in enhanced primary care services for members of the 82nd Airborne Division.

The Prepared Practice: Creating an Office System for Primary Care Management of Depression & PTSD

Every practice or clinic has its own established routines, division of responsibilities, systems for record keeping, and lines of communication among practice members, patients, and specialty services. Practices vary in the degree to which these elements are internally developed or externally mandated. While the military has an electronic record keeping system for medical records (AHLTA), there are internal variations within the primary care system that need to be addressed clinic by clinic as this program is implemented locally. RESPECT-Mil will help practices implement routines, roles and responsibilities, and establish systems to enhance primary care treatment of depression and PTSD.

The RESPECT-Mil Care Facilitator: Providing Soldier and PCC Support

The Care Facilitator supports Soldiers and PCCs by delivering patient education, supporting patient preferences for treatment, monitoring both patient treatment adherence and response, and providing feedback to the PCC about patient progress so that changes in treatment/care plans are made in a timely manner.

The Behavioral Health Interface: Routine Access to a BH Specialist

The BH Specialist is the essential part of the behavioral health interface within the 3CM. As noted earlier the BH Specialist should be a psychiatrist for purposes of providing psychopharmacology and other clinical advice to PCCs. Care Facilitators routinely and systematically consult with the BH Specialist through weekly facilitation staffing sessions. Care Facilitators may contact the BH Specialist more frequently when patient adherence and/or response to treatment warrants. Care Facilitators coordinate communication between the patient, the BH Specialist and the PCC. Psychologists can assist in the staffing process especially for issues of counseling, counseling alternatives and/or patient self-management activities.

*Note: Patients who are under the **primary care of a psychiatrist** for their behavioral health needs are generally not followed by Care Facilitators in this model in order to prevent two doctors prescribing/adjusting medications. Usually more complex patients with inadequate response to treatment by primary care are referred to and managed by behavioral health rather than through primary care.*

Overview of the RESPECT-Mil Care Facilitation Process

The process of care for detecting and managing depression and PTSD in primary care can be divided into distinct steps. These steps are listed below and described in more detail in the following pages.

Table 1: Steps Involving the Care Facilitator are in BOLD and Marked with *

1. Recognition and Diagnosis

Depression	PTSD
• "Flags" for depression	• Four component elements of PTSD
• Two-question screen	• Four-question screen (the PC-PTSD)
• PHQ-9 for depression diagnosis/severity	• PCL for PTSD diagnosis/severity
• Suicide Risk Assessment (if needed)	• Suicide Risk Assessment (if needed)
• Other pertinent diagnostic assessments (PCC)	• Other pertinent diagnostic assessments (PCC)

2. Treatment Selection

- Additional history including previous treatment, co-morbidity
- Explain treatment options – medication, counseling or combination
- Elicit patient treatment preferences

3. Initial Acute Phase Treatment

- Patient engagement
- Provide key educational messages when medication is prescribed
- Establish importance of self-management and goal setting
- Explain and recommend the facilitation process and role of the Care Facilitator

4. Facilitation Process

- *** Initial call(s) to monitor treatment initiation/adherence**
- *** Mail written educational materials (unless provided by the PCC or within the clinic)**
- *** Follow-up calls using PHQ-9 and/or PCL to monitor treatment response and gather information for the PCC's ongoing assessment of treatment response**
- *** Facilitation staffing with psychiatrist**
- *** Coordinate communication between patient, BH Specialist and PCC**

5. Acute Phase Follow-Up

* **Care Facilitator contacts coordinated with primary care office visits**
* **Evaluate patient response to treatment with a goal of remission**
- Modify treatment when sub-optimal response
- Strive for remission

6. Continuation & Maintenance Phase Care

* **Continue treatment response monitoring after remission**
* **Obtain patient responses to maintenance (dysthymia) questionnaire (depression only)**
* **Discuss risk factors/need for long-term prophylactic treatment during care facilitation and staffing**
- Continue counseling and/or antidepressant treatment for four to nine months to prevent relapse
- Continue long-term prophylactic treatment and monitoring for at-risk patients

SECTION II:
THE ROLE OF THE CARE FACILITATOR IN RESPECT-Mil

Care Facilitators are trained to help patients follow through with the depression/PTSD treatment plans prescribed by their PCC. The various Care Facilitator functions are outlined below. Implementation of these functions is discussed in Section VII.

The Goal of Treatment

The goal of the "acute phase of treatment" is remission. After starting and maintaining adequate treatment for a typical interval (i.e., a therapeutic dose of antidepressant and/or specific psychological counseling) many patients will have achieved remission.

Those who do not achieve remission continue in acute phase treatment and are likely to require treatment modifications and adjustments. Some patients will be referred to specialty behavioral health care when an adequate response is not readily achieved and/or when remission is not achieved after six months of management through the primary care setting.

With the goal of remission in mind, the role of the Care Facilitator is to:

1. Monitor the patient's level of adherence to the treatment plan.
2. Support plan adherence and assist in problem solving to overcome barriers to adherence.
3. Monitor treatment response through use of the severity instruments (PHQ-9 and PCL).
4. Routinely communicate information regarding patient progress and adherence to the PCC and BH Specialist.
5. Remind patients of risks for relapse including signs and recommendations if symptoms recur.

Setting the RESPECT-Mil Care Facilitation Process in Motion (Referral)

Several key initial facilitation activities are initiated by the PCC and his/her practice at the time of the initial visit when depression and/or PTSD are diagnosed. These initial activities are:

- Introducing the patient to the role of the Care Facilitator and purpose of the care facilitation process in his or her treatment plan.
- When medication is prescribed at the initial visit, explaining the nature of the medication's effects, its efficacy, potential side effects and their pattern over time (e.g., tend to dissipate over time), the importance of adherence, and the Care Facilitator's role in monitoring adherence.
- Initiating a discussion of the importance and benefits of self-management in overcoming depression and/or PTSD (patient education) and the Care Facilitator's role in monitoring adherence to such.
- Encouraging the patient to set initial self-management goals as part of his or her treatment plan.
- Ensuring the connection (referral) to the Care Facilitator is complete and that the patient is expecting contact by the Care Facilitator within seven to 10 days.

A referral to the Care Facilitator is generally completed through CHCS I (AHLTA) by the PCC and should outline details of initial treatment. Treatment should include at least one of the following:

- Medication
- Counseling
- Specific self-management goals set by the PCC with the patient

Some patients may be introduced directly to the Care Facilitator at the time of the visit when the Care Facilitator is located onsite at the primary care clinic. Co-location is highly desirable for both patient contact and coordination of communication with PCCs in the clinic. Although co-location is the ideal, offsite Care Facilitators can be equally effective in their roles.

Care Facilitator Role in Monitoring Adherence to Treatment

Care Facilitators primarily monitor the patient's adherence to recommended treatment plans throughout the course of his/her treatment. Although routine contacts are made principally by phone, face-to-face in-clinic contacts are acceptable, if more convenient to the patient. Care Facilitators *do not* provide home visits. Each contact is intended to focus on levels of adherence to current treatment including filling/using prescribed medications appropriately/as clinically directed; scheduling/keeping counseling appointments; and setting/following through on self-management goals and activities.

Barriers to Treatment

Patient's experiences/perceptions of barriers to treatment are important and should be the primary focus of Care Facilitator contact with each patient. The Care Facilitator contact is an opportunity for patients to speak openly about concerns regarding treatment and to "think through" (problem solve) how to get beyond any barrier(s). Care Facilitators should focus on facilitating the patient's own problem solving rather than directing or deciding on solutions for the patient. While time-consuming, encouraging patients to make their own decisions is the goal, as such decisions are more likely to be put into practice. Barriers often include, but are not limited to, the items listed below.

General Barriers:

- Fear of military consequences for diagnosis of depression and/or PTSD
- Ambivalence about the diagnosis of depression and/or PTSD
- Concerns about medications and deployment; fear of addiction or stigma related to Rx
- Lack of support or opposition by family members
- Mood and fatigue
- Financial issues relative to military career

Medication Barriers:

- Has not filled prescription
- Has not begun taking medicine
- Not comfortable with/opposed to taking medicine

- Worried about the stigma of being on “depression” medication
- Unclear about what medication does
- Concerns about addiction or drug dependence
- Side effects
- Concern about impact on career

Psychological Counseling/Behavioral Health Treatment Barriers:

- Has not scheduled an appointment with behavioral health
- Does not have ready access to behavioral health counseling (non-urgent)
- Does not have access to support group options
- Had a previous negative experience with behavioral health service
- Fear of initial experience in entering counseling/behavioral health
- Worried about stigma
- Family/friends have negative bias
- Believes peers/military will have negative bias if any contact with behavioral health
- Believes there is no confidentiality protection

Barriers to Continued Treatment:

- Considering stopping or has stopped taking medication(s)
- Concerned about long-term side effect(s)/dependency on medication
- Feeling better and wants to stop treatment
- Lack of improvement
- Lack of family support for and/or acknowledgement of illness and treatment
- Perceived or actual lack of command support
- Wanting to stop counseling because it does not seem to be helping
- Will be deploying and worried about being on medication in theater

In many ways, depression and PTSD themselves may well be a barrier to initiating treatment and/or adhering to the treatment plan. For example, the depressed patient may find it difficult to mobilize the energy to even get to the pharmacy, to take small steps to make a behavioral health appointment or to engage socially with a friend even if just on the phone (completing a self-management goal). A hallmark feature of PTSD is avoidance. That is, PTSD patients are inclined to avoid thinking about or confronting their problems.

Problem Solving Example

Once a barrier has been identified, the Care Facilitator will help the patient to set a reasonable goal to overcome that barrier which will then lead to adherence to the treatment plan.

For example, during week one, the patient was prescribed a medication but has not filled the prescription. This is a primary barrier to treatment and should likely be the full focus on the first contact. The goal for this particular patient would be to get the prescription filled in the next few days and begin taking it as prescribed. Once the patient indicates a willingness to follow through on filling the prescription, the Care Facilitator would then attempt to ensure the patient’s agreement to actually start taking the medication. At this point the Care Facilitator

would set up a follow-up contact with the patient to check on the patient's follow through on both filling and taking the medication as prescribed. In this case, the patient may agree to start the medication on a Friday and the Care Facilitator will contact him/her on Monday or Tuesday to check in to be sure the patient is taking the medication and to determine if there are any side effects from the medication so far.

Care Facilitators frequently must brainstorm with patients about the various ways to achieve goals and facilitate adherence to the treatment plan. The Care Facilitator encourages the patient to creatively think of ways to achieve treatment goals that might be different from their usual ways of coping or interacting. Patients may need to think through exact, detailed steps necessary to take a prescription that will not interfere with their work detail/assignment – i.e., what time of day, how to take the medication with food, how to take medication when in the field, etc.

What may seem like a small barrier to others may indeed seem insurmountable to the patient with depression or PTSD. *Breaking a barrier down into smaller steps reduces the size of the barrier.*

Providing Positive Reinforcement and Encouragement

Patients often require a lot of positive feedback for even the smallest of steps taken toward reaching their goals. The process of improving one's health is an iterative one with the first small step providing the foundation for the next.

Supporting Adherence

The most significant role for Care Facilitators is reinforcing, encouraging and supporting the patient's adherence to treatment. Patients may not initially recognize the importance of all the parts of the treatment plan and may even view it as an obstacle to military activity. This is a particularly important time for the Care Facilitator to reinforce the point that the patient's ability to *fully and ably* fulfill his/her work/military commitment is highly important, and if he/she adheres to the treatment plan, then he/she is far more likely to fulfill his/her commitments.

Some patients may decide to ignore portions of their PCC's recommendations/treatment plan. For example, a patient who would benefit from counseling may be highly resistant to showing up at a behavioral health appointment – even when there is no financial barrier. However, this may be the same patient who will readily talk at great length to the Care Facilitator by phone about the events in his or her life. It is important that the Care Facilitator set limits with the patient at this point; clarifying that issues from the past or lengthy discussions of current psychosocial stressors, etc., are the types of issues that behavioral health specialists are prepared to help with. The Care Facilitator may, in this way, be able to ease the patient into acceptance of counseling with behavioral health.

Care Facilitators are not to play the role of counselor or therapist. Counseling is to occur through resources available through behavioral health and other social support service options. Care Facilitators who find themselves *routinely spending more than 30 minutes* to complete individual patient contacts are likely venturing into the role of a counselor/therapist.

Providing Education Regarding Medication Treatment

The PCC should have communicated key medication/educational messages during the initial

appointment. The Care Facilitator should both verify with the patient that the PCC provided these messages during the visit and then routinely repeat/reinforce these key messages at appropriate times during calls. These messages include:

1. Antidepressants only work if taken every day.
2. Antidepressants are not addictive.
3. Benefits from medication appear slowly over time.
4. Antidepressants should be continued even after the patient is feeling better.
5. Mild side effects are common and usually improve with time.
6. If the patient is thinking about stopping the medication, s/he must call their PCC first.
7. The goal of treatment is complete remission! Sometimes it takes a few tries – do not give up.
8. Once symptoms subside, continued medication or counseling will likely be needed.

Care Facilitators should remind all patients that if they are feeling worse they should not wait until a scheduled office visit – contact their PCC right away.

In addition, taking antidepressants does not automatically lead to medical retirement or a medical evaluation board (MEB). Many Soldiers deploy while taking antidepressants and many others are prescribed them while in theater.

Response to Treatment

While treatment for depression usually takes several weeks before the patient notices a response to treatment, it may take several months for patients with PTSD to notice a response. Medications take some time to bring about changes in brain chemistry that result in a noticeable difference in symptoms. Counseling may take weeks before the patient experiences a desired effect. Acting on individualized self-management goals may have immediate, yet short-term effective impact on mood. It is important to sustain the practice of setting and adhering to self-management goals over time.

As patients are frequently eager to see a quick response, it is a responsibility of the Care Facilitator to help the patient "hang in there" until the more lasting effects of the treatment begin to be evidenced. There may be initial short-term responses/gains that the patient may not recognize or recall over the long term. Care Facilitators should be certain to recount these gains for the patient during routine contacts and encourage further adherence to treatment toward the long-term goal of remission.

> ***Medication Therapy:*** For patients on antidepressants, a measurable initial response to adequate treatment for depression usually occurs in six to eight weeks.

Antidepressant side effects account for as much as two-thirds of all premature discontinuations of antidepressants. Most side effects are early onset and time limited to several weeks (e.g., SSRIs produce decreased appetite, nausea, diarrhea, agitation, anxiety, headache, etc.) and most can be managed by temporary aids to enhance tolerance – food, time of day for administration of medication, etc. Some side effects are early onset and persistent *or* late onset (e.g., SSRIs producing apathy, fatigue, weight gain, sexual dysfunction, etc.) and may require additional medications or a switch in antidepressant. *(See Table 2 on*

the next page for more details on side effects for a variety of medications.)

Psychological Counseling: With psychological counseling alone, an adequate initial response may take somewhat longer and remission may depend on the severity and resolution of the psychosocial stressors.

Table 2: Common Side Effects of Antidepressants

SIDE EFFECT	SSRIs VENLAFAXINE	TRICYCLICs (nortriptyline, amitriptyline, imipramine)	BUPROPION	MIRTAZAPINE	MANAGEMENT STRATEGY
Sedation	+/-	++	-	+	* Give medication at bedtime. * Increase mirtazapine dose. * Try caffeine.
Anticholinergic-like symptoms. Dry mouth/eyes, Constipation, Urinary retention, Tachycardia	+/-	+++	-	+/-	* Increase hydration. * Sugarless gum/candy. * Dietary fiber. * Artificial tears. * Consider switching medication.
GI distress Nausea	++	-	+	+/-	* Often improves in 1-2 weeks. * Take with meals. * Consider antacids or H2 blockers.
Restlessness, Jitters/Tremors	+	+/-	++	-	* Start with small doses, especially with anxiety disorder. * Reduce dose temporarily. * Add beta blocker (propranolol 10-20 mg bid/tid). * Consider short trial of benzodiazepine.
Headache	+	-	+	-	* Lower dose. * Acetaminophen.
Insomnia	+	-	+	-	* Trazodone 25-100 mg po qhs (can cause orthostatic hypotension and priapism). * Take medication in am
Sexual dysfunction	++	-	-	-	* May be part of depression or medical disorders. * Decrease dose. * Try adding bupropion 100 mg qhs or bid. * Try adding buspirone 10-20 mg bid/tid. * Try adding cyproheptadine 4 mg 1-2 hrs before sex. * Consider a trial of Viagra.
Seizures	-	-	+	+/-	* Discontinue antidepressant.
Weight gain	+/-	+/-	+/-	+/+	* Exercise. * Diet. * Consider changing medications.

KEY: - Very Unlikely +/- Uncommon + Mild ++Moderate

Monitoring Response to Treatment Using the PHQ-9 and/or PCL

While the PHQ-9 and/or PCL may be utilized at any point during treatment, they should always be completed, scored and documented during the initial office visit with the PCC and then again at *four week intervals* by the Care Facilitator (during phone contacts) or PCC (during office visits) throughout the *acute phase of treatment*. In a brief time, the key elements of the patient's status may be captured and the Care Facilitator will be able to communicate information to the PCC regarding progress toward remission.

An **adequate initial response** to medication and/or counseling is a **drop in PHQ-9 or PCL score of 5 or more points from baseline** once adequate treatment levels have been established.

Sub-optimal responses occur when the patient does not experience any drop or a sufficient drop in the PHQ-9 and/or PCL scores over time.

Further improvements in severity scores of **5 or more points over each following four-week intervals** are the goal and adjustments to treatment should be made by the PCC often based on BH Specialist advice.

Since Care Facilitators are NOT expected to assess adequacy of response to treatment, detailed guidelines for treatment changes are not included here. The PCC is ultimately responsible for assessment of the adequacy of treatment response. The BH Specialist will usually provide guidance on this assessment which is communicated by the Care Facilitator.

Care Facilitator progress monitoring for both depression and PTSD should always begin at least as soon as seven to 10 days from diagnosis/referral. At that time the Care Facilitator confirms the patient has initiated treatments prescribed and determines if there are any initial barriers to treatment. All subsequent routine contacts occur at approximately four week intervals from the initial referral date. These contacts involve discussion of the prescribed treatment plan and obtaining responses to the questions on the PHQ-9 and/or PCL questionnaires.

An earlier initial contact may be warranted with Soldiers who had some level of suicidal ideation indicated on the PHQ-9 or PCL. More frequent calls may also be necessary for patients who have not been able to self-initiate and/or follow through on their treatment goals or for those who present concerns to the PCC and/or Care Facilitator relative to safety. The Care Facilitator generally decides on his/her own that additional (PRN) calls are needed. In addition, the PCC and/or the BH Specialist may request more frequent contacts for patients who are particularly in need.

Coordinating the Communication of Information

Since the Care Facilitator has frequent and sustained contacts with the patient (providing the opportunity to relay information from the patient to the PCC) and frequent contact with the BH Specialist, s/he serves as a unique link between primary care and behavioral health specialists in a way that benefits the patient.

In weekly Care Facilitator staffing sessions, the BH Specialist provides on-going treatment management advice regarding all patients in the program and offers recommendations for treatment changes, which either the Care Facilitator or the BH Specialist will communicate to the PCC. Action items during the staffing call itself should be made regarding who will contact the PCC and in what format (e.g., telephone, e-mail, face-to-face, etc.).

Remission Criterion for Depression

Remission from depression is defined as:

A score of <5 points on the PHQ-9 that is maintained consistently over eight consecutive weeks or more.

- If remission has continued for eight weeks, obtain responses to the questions contained in the Maintenance Questionnaire which evaluates risk factors for dysthymia.
- Advise the patient that the questions will help his/her PCC decide upon next steps in treatment.
- Emphasize to patient that medications, counseling and self-management activities should not be discontinued even if in remission. Medications should only be stopped with the advice of the PCC.
- Discuss risks and signs of relapse by reminding patient of the symptoms that were bothering him/her the most based on the PHQ-9 completed at the time of diagnosis and referral.
- Discuss the patient's responses to the Maintenance Questionnaire during staffing for a determination of presence of dysthymia. Report results/recommendations to PCC for consideration/discussion with patient.

Remission Criterion for PTSD

Remission from PTSD is:

A score of <11 points on the PCL attained within six months of initiating active treatment.

- Remission for PTSD will likely occur more slowly.
- Begin looking for PTSD remission at week 12 and beyond.
- There is no comparable questionnaire for chronic PTSD as there is for dysthymia.
- Emphasize to patient that medications, counseling and self-management activities should not be discontinued even if in remission. Medications should only be stopped with the advice of the PCC.
- Discuss risks and signs of relapse by reminding patient of the symptoms that were bothering him/her the most based on the PCL completed at the time of diagnosis and referral.

SECTION III:
USE OF THE PHQ-9 IN DEPRESSION MANAGEMENT

The nine depression symptom questions from the PHQ-9 are derived directly from the DSM-IV diagnostic criteria for major depression. A 10th question asks about functional impairment from these symptoms in relation to daily activities of living.

Depression Screening

Screening for depression during the vital signs process at the beginning of a primary care visit occurs through use of two questions from the PHQ-9. These screening questions are displayed in Figure 1 below. A positive endorsement of one or both of the questions should lead to the completion of the full PHQ-9 itself.

Figure 1: MEDCOM Form 774 - Two-Question Screening for Depression (PHQ-2)

MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING
For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen.
Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE:

Over the **LAST 2 WEEKS**, have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless	☐ Yes	☐ No
2. Little interest or pleasure in doing things	☐ Yes	☐ No

Have you had any experience that was so frightening, horrible, or upsetting that **IN THE PAST MONTH**, you . . .

3. Had any nightmares about it or thought about it when you did not want to?	☐ Yes	☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	☐ Yes	☐ No
5. Were constantly on guard, watchful, or easily startled?	☐ Yes	☐ No
6. Felt numb or detached from others, activities, or your surroundings?	☐ Yes	☐ No

PATIENT IDENTIFICATION *(please print):*

NAME (Last, First, MI): _____

DOB: ____/____/____ *Unit:* _____

Rank: _____ *SSN:* ___-___-___

Phone: (Home/Cell): _____

(Unit/Work): _____

MEDCOM FORM 774 (MCHL-DHC) AUG 2007 MC PE v2.00

The PHQ-9 for Depression

The PHQ-9 is used as a patient self-administered questionnaire in the office or read to the patient over the telephone to help confirm a depression diagnosis and determine severity. The Care Facilitator obtains updated patient responses to the questions of the PHQ-9 and the functional impairment question at four week intervals. The responses to the questions serve as a treatment response monitoring mechanism which the PCC may use to evaluate patient progress. Based on the outcomes of these four week reviews, treatment decisions may be made by the PCC to modify or switch medications; add counseling; and/or adjust self-management goals and activities in an effort to reach remission. In addition, lack of response to treatment as measured by the PHQ-9 may lead the PCC to refer the patient to specialty care.

A sample of a completed PHQ-9 is presented on the following page in Figure 2. Immediate subsequent pages provide guides to counting symptoms as reported by the patient as well as a guide for scoring the questionnaire for severity. It is important to take time to study how to both count symptoms and calculate the severity score. Care Facilitators should always verify and, occasionally correct, scores on PHQ-9s sent by PCCs when referring patients. If an error is noted, the PCC should be advised of the corrected symptom count and/or score so that the accurate information may be recorded in the patient's medical record (AHLTA when available).

As Care Facilitators contact the patient to obtain response to the PHQ-9 it is important to remind patients to focus on the *prior two week interval* (not months or years) when completing the questionnaire. Such reminders will aid the patient in completing the questions more easily. The updated scores are communicated to the PCC through a Care Facilitator Report or electronically through AHLTA in the form of a Telephone Consult (T-Con).

Figure 2: Sample Completed (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	(1)	2	3
2	Feeling down, depressed, or hopeless	0	1	(2)	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4	Feeling tired or having little energy	0	1	2	(3)
5	Poor appetite or overeating	0	(1)	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	(2)	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	(1)	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	(1)	2	3
	add columns:		+	+	
	TOTAL:				

10	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	 ✓

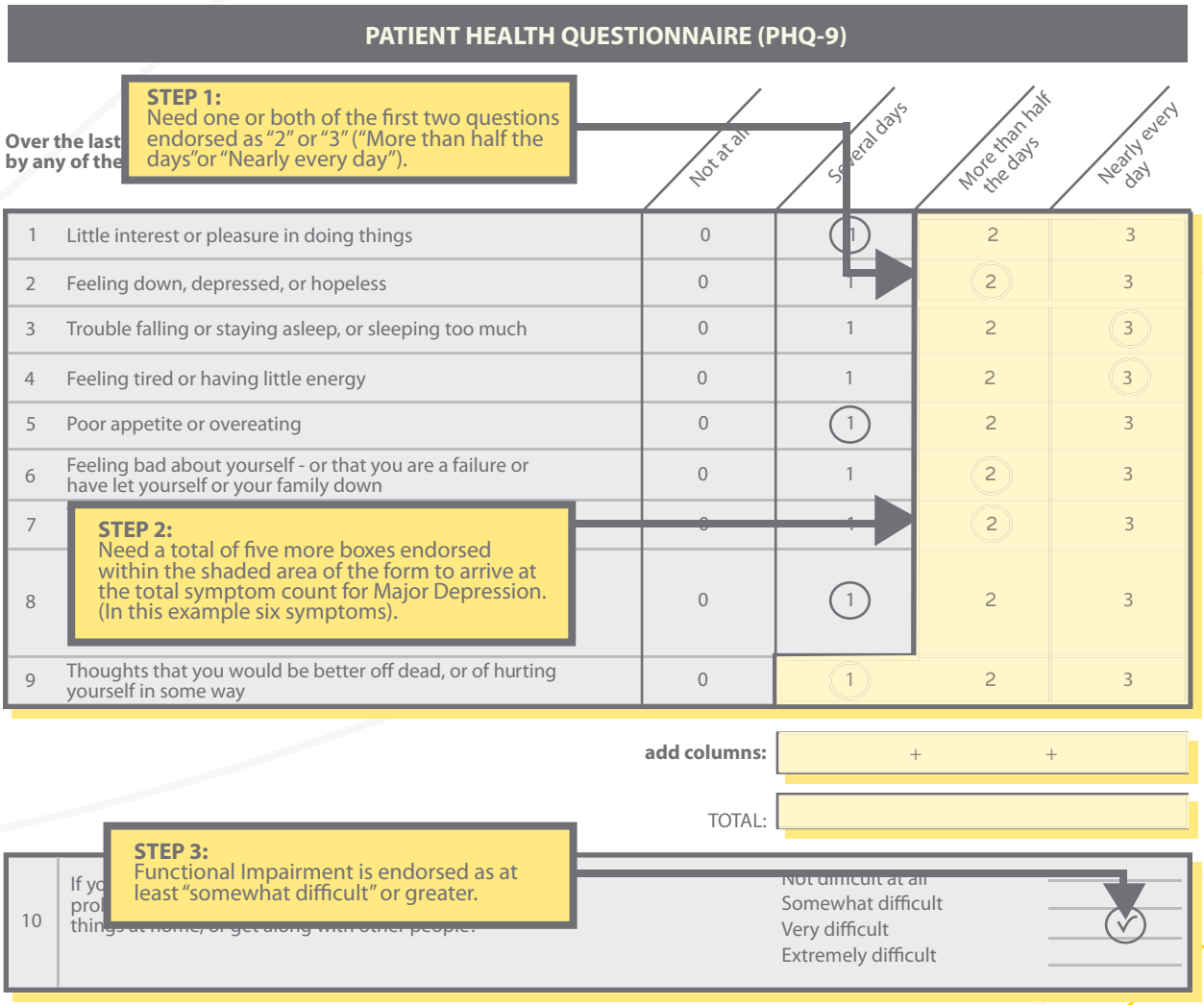
Guide for Counting the PHQ-9 Symptoms

The number of symptoms and functional impairment endorsed on the PHQ-9 are examined to make a tentative diagnosis of major depressive disorder by looking for three criteria.

- Each of the nine questions represents a symptom (per the DSM IV). Therefore, the maximum symptom count possible is nine.
- One of the first two questions should be endorsed at two to three points for a diagnosis of depression.
- Responses to questions one through eight of *"more than half the days"* (two points) OR *"nearly every day"* (three points) count as a symptom. *One symptom per question*.
- The **exception** is question number nine which evaluates suicidal ideation. Any response other than "not at all" (zero points) counts as a symptom.
- A positive answer to question nine requires immediate follow-up and assessment for suicide risk by the PCC.

In the example in Figure 3, the criteria for major depressive disorder (MDD) are met. The second question ("Feeling down, depressed, or hopeless") is endorsed more than half the days, a total of six of the nine symptoms are within the shaded area, and there is functional impairment from the symptoms.

Figure 3: Counting Depression Symptoms Using the PHQ-9



Guide for Calculating the PHQ-9 Severity Score

A total depression severity score is obtained from the PHQ-9 by summing the values of all endorsed (circled or checked) responses. This is most easily done by:

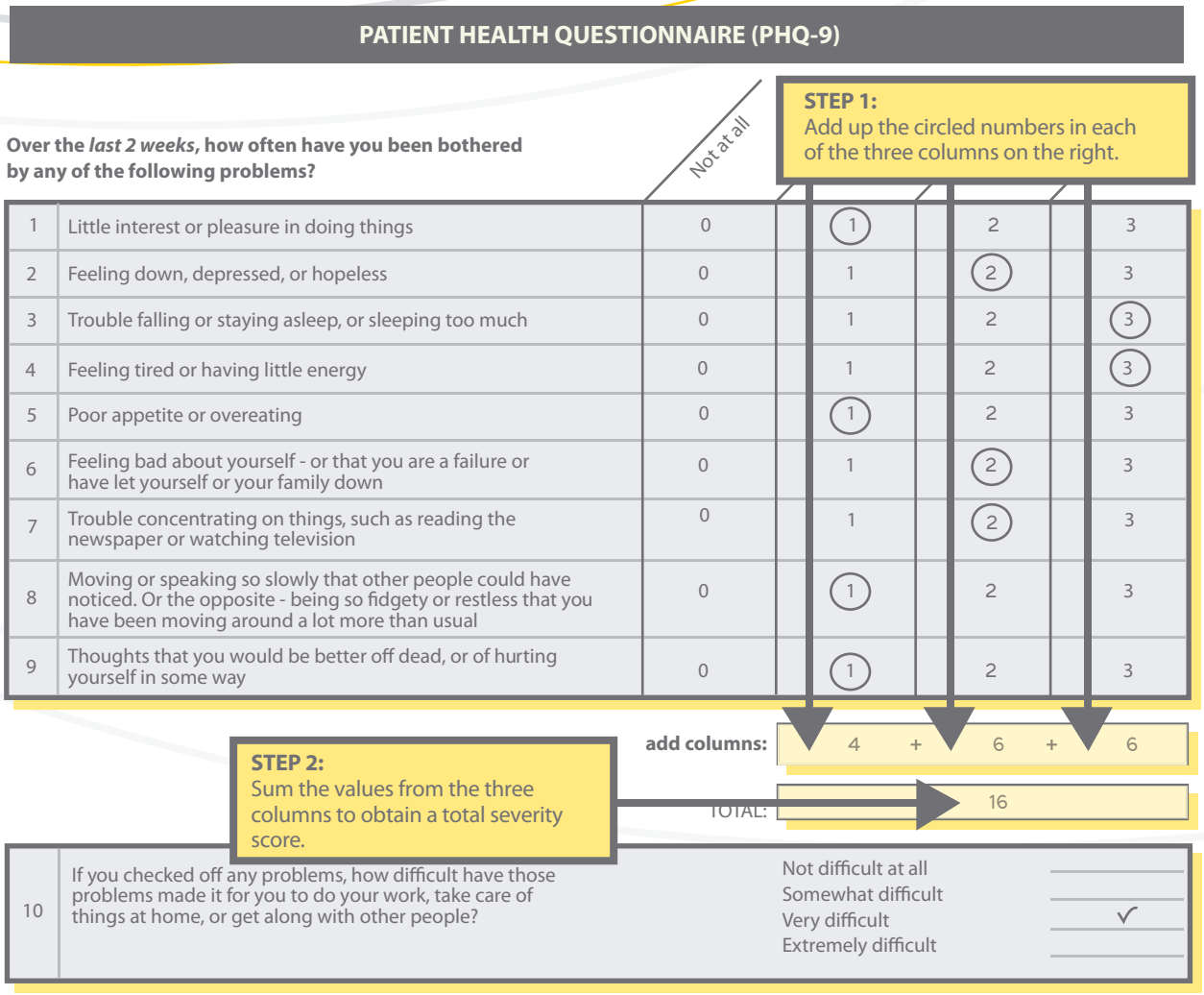
1. Adding the values in each endorsed box in each of the three columns.
2. Summing the totals from each of the three columns.

The severity score is extremely useful in determining if/how to treat depression and then to monitor the progress of treatment.

- A PHQ-9 severity score can range from zero to a maximum of 27 points.
- ALL points are summed including those that are not in the shaded symptom-count areas.

The example in Figure 4 displays a severity score of 16 which falls within the range for MDD. See Table 3 for information regarding provisional diagnoses based on use of the PHQ-9.

Figure 4: Calculating the Depression Severity Score Using the PHQ-9



Provisional Diagnosis Categories and Treatment Options

Table 3 provides a guide for provisional diagnosis of depression which may be used by PCCs. This table is presented for *reference only* and should never be used by Care Facilitators to advise patients of severity of depression. Additionally, the PHQ-9 score never replaces a PCC's clinical judgment. Some scores that appear low may occur if the patient is withholding information which the PCC may be able to gather through clinical evaluation or may also indicate some chronicity which would also be determined through the clinical assessment.

Table 3: Provisional Diagnosis Based on PHQ-9 Severity Scores

PHQ-9 Score	Provisional Diagnosis	Treatment Options
0-4	No depression	N/A
5-9	Minimal symptoms*	Support, educate to call if worse; return in one month.
10-14	Minor depression++ Dysthymia* Major depression, mild	Support, watchful waiting. Antidepressant or psychotherapy. Antidepressant or psychotherapy.
15-19	Major depression, moderately severe	Antidepressant or psychotherapy.
>20	Major depression, severe	Antidepressant *and* psychotherapy (especially if not improved on monotherapy).

** If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask, "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?").*

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment.

Monitoring of Patient Response to Treatment

Table 4 is intended for reference only and is not intended for Care Facilitator decision making or as a source for advice to patients. PCCs will use the information here as they plan treatment with/for their patients.

Table 4: Treatment Response Guide for Depression

Initial Response After Six to Eight weeks of Adequate Dose of an Antidepressant		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2 – 4 points from baseline	Probably Inadequate	Often warrants an increase in antidepressant dose.
Drop of 1 point or no change or increase	Inadequate	Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling.
Initial Response to Psychological Counseling After Three Sessions over Four to Six Weeks		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 2 – 4 points from baseline	Probably Inadequate	Possibly no treatment change needed. Share PHQ-9 with psychological counselor.
Drop of 1 point or no change or increase	Inadequate	If depression- specific psychological counseling (CBT, PST, IPT) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant. For patients dissatisfied in other psychological counseling, review treatment options and preferences.

SECTION IV:
USE OF THE PCL IN PTSD MANAGEMENT

The process of care for PTSD is nearly identical to that for depression. Just as with depression there is a brief screening form and a longer diagnostic and severity assessment form. Initial treatment and patient engagement are similar while the facilitation process and BH Specialist staffing are the same.

Four Components for PTSD Diagnosis

1. Traumatic experience.
    - Soldier experienced or witnessed an event that involved actual or threatened death or serious injury.
    - Soldier's response involved intense fear, helplessness or horror.

2. Symptoms in each of the following categories.
    - **Re-experiencing** of event (*at least one*):
        - Images, thoughts, perceptions
        - Nightmares
        - Flashbacks
        - Reminders cause psychological distress
        - Reminders cause physiological reaction
    - **Avoidance** of stimuli associated with the trauma and numbing of general responsiveness (*at least three*):
        - Avoid thoughts, feelings, conversations of trauma
        - Avoid activities, places, people that arouse recollections of trauma
        - Inability to recall aspects of trauma
        - Diminished interest or participation in activities
        - Feeling detached or estranged from others
        - Restricted range of affect
        - Sense of foreshortened career, marriage, or life
    - **Arousal** (*at least two*):
        - Insomnia
        - Irritability
        - Difficulty concentrating
        - Hyper-vigilance
        - Exaggerated startle response

3. Functioning at work, home, or socially is impaired.

4. Condition is persistent over at least one month.

Screening for PTSD

As with depression, recognizing that a patient is suffering from PTSD is challenging. Many patients may also be suffering from depression, may be irritable and angry, and may be concerned about stigma because of their reaction to trauma and the possibility of a psychiatric diagnosis.

To aid with identification of PTSD, a four-question screen is utilized by the clinic along with the two-question screen for depression. The patient answering "yes" to *two or more of the four questions* should lead to the completion of the full PCL itself.

NOTE: RESPECT-Mil uses the PCL not the PCL-M. In addition, we utilize a 0-4 point scale for each question and not a 1-5 scale used by many other programs.

Figure 5: PTSD Four-Question Screen for PTSD

MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING
For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen.

Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE:

Over the **LAST 2 WEEKS,** have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless	☐ Yes	☐ No
2. Little interest or pleasure doing things	☐ Yes	☐ No

Have you had any experience that was so frightening, horrible, or upsetting that **IN THE PAST MONTH**, you . . .

3. Had any nightmares about it or thought about it when you did not want to?	☐ Yes	☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	☐ Yes	☐ No
5. Were constantly on guard, watchful, or easily startled?	☐ Yes	☐ No
6. Felt numb or detached from others, activities, or your surroundings?	☐ Yes	☐ No

The PCL

Similar to the PHQ-9 for depression, the PCL incorporates the DSM-IV 17 criteria for PTSD into a self-administered questionnaire that helps confirm a PTSD diagnosis and determine severity. The PCC discusses the reasons for completing the PCL with the patient and explains how to fill it out. We have added both the suicide risk question and the functional impairment question as questions 18 and 19 respectively. Neither of these items is to be added into the symptom count or severity score.

Counting the Symptoms in the PCL

Based on the number of symptoms present at least at a moderate level (≥ 2) in each of the three categories – intrusion, avoidance and arousal – in the past month, a total severity score > 13, plus the presence of functional impairment, the PCC can formulate a working PTSD diagnosis.

Within each symptom category there are a minimum number of symptoms with a score of at least three (moderately bothered) that are required to substantiate a diagnosis. These are outlined below and illustrated in the next few pages on a sample completed PCL form.

Table 5: Minimum Symptom Counts by Category for a Provisional Diagnosis of PTSD

Category	Minimum Endorsement
Intrusion	1 out of 5 questions in category
Avoidance	3 out of 7 questions in category
Arousal	2 out of 5 questions in category
TOTAL SYMPTOMS	6 out of 17 questions by categories noted above

- Each of the questions represents a symptom (per the DSM IV). Therefore, the maximum symptom count possible is 17.
- A symptom is counted when the question is endorsed as "moderately," "quite a bit," or "extremely." (Items endorsed as 2, 3, or 4 points.)
- *One symptom per question.*

Figure 6: Symptom Count for Diagnosis of PTSD Using the PCL

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month.*** Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a experience from the past?			2	3	4
	3	Suddenly acting or feeling as if a experience were happening aga reliving it)?			2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations bec you of a stressful experience fro			2	3	4
	8	Trouble remembering important stressful experience from the past?			2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry			2	3	4
	15	Having difficulty concentrating?			2	3	4
	16	Being "super alert" or watchful o			2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
		For Primary Care Provider - Subtotal		+	+	+	+
					Total =		
	18	If you checked off any of the above problems, how difficult have these problems ma things at home, or get along with other people? _____ Not difficult _____ Somewhat difficult __X__ Very difficult _____ xtremely difficult					
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____ Yes __X__ No If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day					

INTRUSION:
At least 1 from items 1 thru 5 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

AVOIDANCE:
At least 3 from items 6 thru 12 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

AROUSAL:
At least 2 from items 13 thru 17 endorsed 'moderately' (2 pts) or above (3 or 4 pts)

FUNCTION (question 18):
At least 'somewhat difficult'

Calculating the PTSD Severity Score from the PCL

A total PTSD severity score is obtained from the PCL by summing the values of all endorsed (circled or checked) responses. This is most easily done by:

1. Adding the ALL values in each endorsed box in each of the three columns.
2. Summing the totals from each of the three columns.

The minimum PCL score is zero and the maximum score is 68.

Figure 7: Sample of Completed PCL

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully and circle the number in the box which indicates how much you have been bothered by that problem ***in the last month***. Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	(1)	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	(2)	3	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	(3)	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	(4)
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	(3)	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	(3)	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	(2)	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	0	(1)	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	(1)	2	3	4
	10	Feeling distant or cut off from other people?	0	1	(2)	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	(3)	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	(4)
TWO	13	Trouble falling or staying asleep?	0	1	(2)	3	4
	14	Feeling irritable or having angry outbursts?	0	1	(2)	3	4
	15	Having difficulty concentrating?	0	1	2	(3)	4
	16	Being "super alert" or watchful and on guard?	0	1	2	3	(4)
	17	Feeling jumpy or easily startled?	0	(1)	2	3	4
		For Primary Care Provider - Subtotal	0 +	4 +	10 +	15 +	12
					Total = 41		

	18	If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____ Not difficult _____ Somewhat difficult __X__ Very difficult _____ Extremely difficult
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____ Yes __X__ No If 'Yes,' how often? _____ Several days _____ More than half the days _____ Almost every day

Using PCL Results to Help Determine Treatment Selection

The following table provides a guide for provisional diagnosis of PTSD which may be used by PCCs. This table is presented for *reference only* and should never be used by Care Facilitators to advise patients of severity of PTSD.

Table 6: Provisional Diagnosis of PTSD Using the PCL

PCL Symptoms & Impairment	PCL Severity	Provisional Diagnosis	Treatment Recommendations
< 6 symptoms at moderate or greater severity, but functional impairment.	< 13	Sub-threshold or no PTSD	- Reassurance and/or supportive counseling - Education
≥ 6 symptoms at moderate or greater severity • ≥ 1 intrusion symptom • ≥ 3 avoidance symptoms • ≥ 2 arousal symptoms plus functional impairment.	13-32	PTSD, Mild	- SSRI - If no improvement after 12 weeks, refer for Cognitive Behavioral Therapy - Specialty referral*
	≥33	PTSD, Moderate to Severe	

**Refer for co-management with behavioral health specialty provider if patient is:*

- *High suicide risk*
- *Has substance abuse*
- *Has complex psychosocial needs and/or*
- *Other active mental disorders (except depression)*

SECTION V:
SUICIDALITY

Suicidal thoughts are one of the symptoms of depression and may also be present in those with PTSD. Approximately 10 percent of people with untreated major depression eventually commit suicide. Suicidality may not be an emergent (crisis) or urgent symptom, but it is always serious.

There is no good way to predict in the short term who will commit suicide, although long-term risk is correlated with the following risk factors:

- Hopelessness
- Prior suicide attempts
- Living alone
- Comorbid anxiety
- Substance abuse
- Male gender
- Caucasian race
- General medical illnesses
- Family history of substance abuse

Levels of Suicide Risk

Emergent Risk Level:

If the patient has an *active desire* to commit suicide and has *no self-control or external supports* for safety (e.g., family and friends) then a *safe means for transport to the nearest emergency room* setting should be found.

Urgent Risk Level:

If a patient *has suicidal plans* but is *without an active desire* to commit suicide. This is an urgent situation and could become an emergent one. The patient should receive a *behavioral health assessment within 48 hours* from a behavioral health specialist and/or their PCC. Take steps to ensure that an assessment will occur. *Do NOT leave it up to the patient to arrange this!*

Low Risk Level:

If the patient *has no suicidal plans* and *no active desire* to commit suicide, s/he would be considered a low risk. Further assessment is not necessary at the time. The Care Facilitator should continue to *monitor any changes in this status with every contact* and report any changes that indicate increased risk to the PCC or emergency staff according to steps above.

Components of an Evaluation for Suicidal Risk

- Presence of suicidal ideation including **intent** and/or **plan**
- Access to **means** for suicide and the **lethality of those means**
- **History** and seriousness of previous attempts
- **Lack of social support**

Care Facilitators must be prepared to respond to a suicidal patient on the other end of a phone line at *any time.* Care Facilitators should discuss (talk through) options for emergent events in advance with supervisors and/or clinic administration to develop a response plan if the Care Facilitator is faced with an emergent and/or urgent patient suicidal risk situation. Each clinic or post should have a Safety SOP which has been developed and approved locally.

Care Facilitators and RESPECT-Mil are NOT rapid response teams or hotlines for risk emergencies. Clinics with an actively suicidal or homicidal patient need to utilize their own safety protocol and not call the Care Facilitator to intervene.

As a Care Facilitator, NEVER be unprepared!

Know how to contact emergency response teams (911) without disconnecting from the patient.

(Use an extra phone line or cell phone and/or access other staff in immediate area to call 911.)

Know your patient as best you can – get them to contract with you for safety **(discuss 'contracting' locally and make decision on when to employ it).**

Practice in advance.

Do NOT wait until you are on the line with a patient in distress.

Suicide Risk and the PHQ-9 and PCL

The PHQ-9 and a modified RESPECT-Mil version of the PCL can be used at any time as a tool to begin to evaluate suicidal ideation if you are in conversation with a patient and observe a need to inquire about suicidal thoughts. Specifically, question nine on the PHQ-9 and question 19 on the PCL, asks patients…*"In the last two weeks, how often have you had thoughts you would be better off dead or of hurting yourself in some way?"*

Any positive response to question nine or 19 – anything more than "not at all" – warrants a determination as to whether there are "passive suicidal thoughts" *(i.e., "…thoughts you would be better off dead…")*

OR

whether there are any "active suicidal thoughts" *(i.e., "thoughts of hurting yourself in some way").*

There is *no* way to tell the difference between *active* and *passive* suicidal thinking without further questioning of the patient.

The following section provides an easy-to-use strategy to distinguish between *passive* and *active* thoughts of death. Of course, this is only necessary for that small percentage of patients who indicate a positive response to the questions indicated italics above. Care Facilitators must know that some patients who do not originally reveal any active suicidal thoughts may "convert" to the demonstration of active suicidal thinking. Care Facilitators may need to use the suicide risk questionnaire on more than one occasion on any given patient.

ALL SUICIDE RISK QUESTIONNAIRES COMPLETED MUST BE DISCUSSED WITH THE BH SPECIALIST – AT THE *LATEST* DURING THE NEXT STAFFING CALL.
(Make contact earlier if any doubt.)

Figure 8: Care Facilitator Suicide Risk Form

Record Statements in Detail -
Refer to Guidance Notes on Back of Form

Patient Name: _____ PCM: _____ Pt. ID#: _____
Date and Time of Call: _____ RCF Name: _____

1. "In the past month, have you made any plans or considered a method that you might use to harm yourself" (circle one)

YES NO

(If yes, ask, *"Please be specific about these plans or methods you have considered."*)

_____

_____

_____

2. "Have you ever attempted to harm yourself?" (circle one)

YES NO

(If yes, ask, "*When was this? What happened?*")

_____

_____

_____

3. "There's a big difference between having a thought and acting on a thought. Do you think you might actually make an attempt to hurt yourself in the near future?" (circle one)

YES NO

(If yes, ask, "*Can you be specific about how you might do this?*")

_____

_____

_____

4. "In the past month have you told anyone that you were going to commit suicide, or threatened that you might do it?" (circle one)

YES NO

(If yes, ask, "*Who have you told and what have you said to them?*")

_____

_____

_____

5. "Do you think there is any risk that you might hurt yourself before you see your doctor the next time?" (circle one)

YES NO

(If yes, ask, "*What do you think you might do?*")

_____

_____

_____

Action taken to contact PCM (indicate "none" if pt. determined at "low risk").

_____

_____

NOTE: All patients with a suicide risk review conducted are to be reviewed with the BH Specialist in a timely manner. This may require immediate contact or may be conducted during staffing depending on level of risk. Only a low risk outcome with no active ideation may wait until the usual staffing session - all others warrant prompt attention.

Guidance Notes for Care Facilitators Regarding Response to Risk Levels

These guidance notes are intended to facilitate the gathering of appropriate information/detail during the conversation and risk review with the patient. That information/detail would then be shared with the PCC and BH Specialist. This should not be considered a basis for decision making by the Care Facilitator; however, they would guide the action plan to be taken as outlined in the various scenarios below. The FIRST STEPS system will provide immediate indicators to the Care Facilitator regarding the timeline for staffing with the BH Specialist ranging from weekly to one duty day to immediate. Local actions regarding 911 should be guided by local Safety SOPs approved by the individual post.

Positive ("YES") Response to Question 5: "Active suicide thoughts: ACUTE RISK"

1. If patient's response is "YES" to question five, the patient will be considered **"EMERGENT/HIGH SUICIDE RISK."**
2. The Care Facilitator must contact the patient's PCC (or the covering/on-call PCC) immediately to expedite a clinical evaluation. *(If there is on-site behavioral health, this will serve as a primary alternative to PCC assessment. The PCC must still be contacted.)*
3. If the patient presents an obvious acute risk, stay on the phone with the patient, call 911, and/or initiate best actions to ensure that the patient goes immediately to an emergency room.
4. If there is another adult with the patient, then attempt to speak with that person and get assurances that s/he will accompany the patient to an emergency room OR that he/she will dial 911 if they do not have ability or means to transport.
5. Inform the patient's PCC (or on-call PCC) immediately by telephone or direct contact.
6. If the PCC or on-call PCC is not readily available, then the Care Facilitator should next attempt to reach the BH Specialist (or the covering/on-call psychiatrist/BH Specialist).

Positive ("YES") Response to Questions 1-4: "Active suicidal thoughts: MODERATE TO HIGH RISK"

1. If the patient has any positive answer ("YES") to questions one through four, the patient will be considered "URGENT/MODERATE TO HIGH RISK."
2. This information must be communicated to the patient's PCC (or the covering/on-call PCC) immediately via telephone or direct contact.
3. Patients at this level of risk should be assessed by a qualified BH Specialist within 48 hours.
4. If the PCC or on-call PCC is not readily available, then the Care Facilitator should next attempt to reach the BH Specialist (or the covering/on-call psychiatrist/BH Specialist).

Negative ("NO") Response to Questions 1-4: "Active suicidal thoughts: LOW RISK"

1. If the patient answers "NO" to questions one through four, the patient will be considered a "LOW SUICIDE RISK." This information should be communicated to the PCC via usual facilitation lines of communication.

Adapted from Cole S, 'Care Management Suicide Assessment Form,' developed for the Collaborative on Depression in Primary Care, Bureau of Primary Healthcare, unpublished document.

SECTION VI:
CONTINUATION & MAINTENANCE

Risk of Relapse - Depression

Figure 9: Long-Term Care

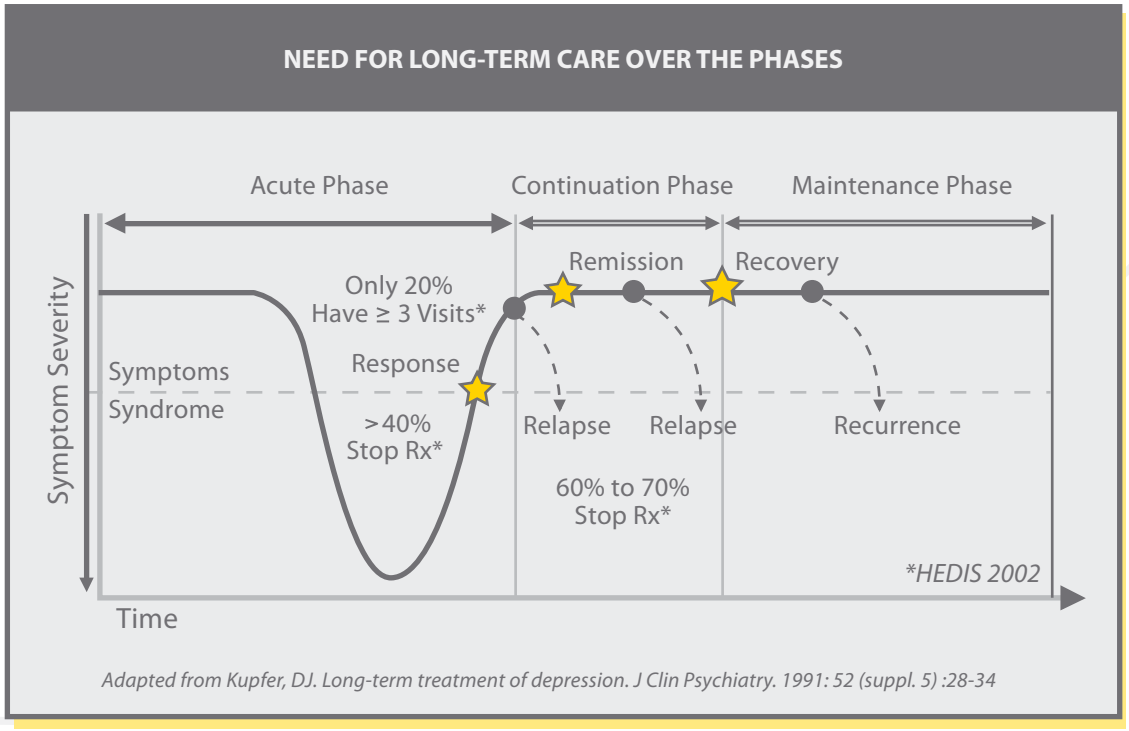


Figure 9 above identifies the definition of treatment outcomes during the long-term treatment of depression. The goal of the acute phase of treatment is to achieve full symptom remission defined as a PHQ-9 score of < 5 points. The outcomes are similar for PTSD with remission defined as a PCL score of < 11 points.

The risk of relapse during the first six months after achieving remission from depression is as high as 50 percent. Over a person's life time the risk of recurrent episodes of depression is even higher, averaging 60 percent to 75 percent. The goal of continuation phase treatment is to keep patients in remission. Continuation of antidepressants for four to nine months after achieving remission considerably reduces risk for relapse.

Some patients with recurrent episodes of depression are at significantly higher risk for future episodes of depression. The goal of maintenance phase treatment is to identify these patients and keep such patients on active treatment. Many depressed patients decide on their own to discontinue taking prescribed antidepressants after remission begins. Even fewer patients with a high risk of recurrent episodes receive maintenance treatment. These characteristics of depression treatment make it similar to other chronic diseases like asthma or diabetes which require a chronic disease approach, not just an acute disease approach.

Continuation

All patients with depression and/or PTSD who enter remission should receive education to recognize signs of relapse early on and to request an appointment with their PCC or behavioral health provider as soon as possible.

Medications

Patients who successfully achieve remission on medication during the acute phase should take the same dose of that medication for four to nine months once remission occurs and then taper off the medication over several weeks under the direction of their PCC. Many patients do not refill antidepressant prescriptions during the continuation and maintenance phases. The absence of symptoms often will give the patient a sense that the disorder is "cured" so there is no need for further treatment. As with many illnesses, the absence of new symptoms does not mean the problem is completely resolved. Therefore, the Care Facilitator plays an important role in ongoing monitoring and promoting adherence to long-term treatment plans.

Psychological Counseling

A decision to use psychological counseling during continuation depends on the symptoms, psychosocial problems, and recommendation of the BH Specialist.

Care Facilitator Role

Regardless of the selection of continuation medication and/or psychological counseling or discontinuation of treatment, the Care Facilitator plays a pivotal role by monitoring remission through use of the PHQ-9 and/or PCL with results reviewed by the PCC. Use of the Maintenance form should occur (at a minimum) during at least one call during the continuation phase.

During the continuation phase, the Care Facilitator also monitors risk factors (see Table 6 below and the Maintenance Questionnaire on page 37) for recurrence to assist the BH Specialist and PCC in recommending whether or not to continue treatment into a maintenance phase. At the end of the continuation phase, patients who sustain their remission are considered to have achieved recovery (see Figure 9 on page 33). Those without risk factors should generally discontinue antidepressants, again only upon the advice of their PCC.

Factors for Risk of High Recurrence of a Depressive Episode

1. Dysthymia (chronic depression)
2. History of two or more previous episodes of depression
3. History of recurrence of depressive episode within one year
4. History of one other episode within three years and that the current episode was sudden and life threatening

What is Chronic Depression? (Dysthymia):

The essential feature of dysthymia (or dysthymic disorder in DSM-IV) is a chronically depressed mood that occurs for *most of the day, more days than not, for at least two years*. The mood may be one of irritability rather than depression. In addition, a minimum of two other symptoms must be present such as poor appetite, overeating, insomnia, hypersomnia, low energy, fatigue, low self-esteem, poor concentration, and/or difficulty making decisions.

Chronic depression can present itself in several different ways. In one mode, it begins in adolescence or young adulthood and is frequently more likely a long-term personality style than an affective disorder. A second type is associated with major depression. Dysthymia can follow an episode of major depression and subsequently co-occur with recurrent episodes of major depression. A third mode occurs following chronic medical disease and/or bereavement, particularly in older persons. In each case, the duration of the pattern is a minimum of two years.

Major depression consists of one or more discrete episodes distinct from usual mood and function. In contrast, dysthymia is chronic, less severe, present for many years, and hard to distinguish from one's usual function and mood.

Why is a Chronic Depression Diagnosis Important?

Evidence-based reviews of antidepressant treatment for dysthymia suggest antidepressants are effective. Short-term studies suggest some patients with dysthymia respond to placebo, but in the long term this response is not well maintained. Thus, all patients with dysthymia should generally be advised to have at least one 12-month trial of adequate doses of an antidepressant. This is often difficult because of poor adherence for this length of time.

What Questions Can Help Elicit a Diagnosis of Chronic Depression?

See the Maintenance Form (which follows) for a brief interview guide for DSM-IV dysthymia in the maintenance phase. Interpretation of the answers can be helped by additional questions. A standard question is, "In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?" Another alternative is, "Have you been bothered by feeling depressed or low much of the time for the past two years? How much of the time have you felt this way?" In addition, asking when the patient last remembers being really happy is a useful question that gets more at the concept and is more open ended. Someone with dysthymia since young adulthood will have difficulty remembering period(s) of being really happy for more than a couple of months. Such persons often see everything in shades of gray and can convey such an outlook whenever you are with them.

Asking about any episodes of past, more severe, depression (or other psychiatric disorders requiring treatment) and the relationship of these episodes to the onset of a chronic period of low mood or anhedonia is helpful. Sometimes another chronic psychiatric disorder is associated with the onset.

Some persons can clearly remember and convey lengthy periods of feeling happy and do not have any past history of major depression. Instead they experience one or more difficult or challenging life events in adulthood that result in a persistent change in confidence and mood.

Each of these three types can have a positive response to antidepressants and warrant at least one adequate trial, for a year or longer.

When Should the Maintenance Questionnaire Be Utilized?

Care Facilitators should plan to use the questionnaire **AFTER** the **patient has maintained remission (score of <5 on the PHQ-9) for at least eight consecutive weeks**.

For example, a patient achieves remission at eight weeks with a score of four, but regresses at 12 weeks to a score of 11. At a 16 week contact, the score has improved to three. The measure of maintained remission would **begin again at 16 weeks**. PHQ-9 measures would

then be taken at 20 and 24 weeks with the Maintenance Questionnaire completed at 24 weeks assuming remission was continuously maintained since the 16 week measure.

Maintenance

After the PCC and/or BH Specialist assess risk factors for recurrent depression, a decision is made whether or not to continue prophylactic maintenance treatment for at risk patients.

For those continuing in maintenance with prophylactic treatment, education of the patient regarding early signs of recurrent depression should be completed. It is important to help them try to remember how their depression first appeared so they can identify recurrence as early as possible. The PHQ-9 should periodically be completed and responses reviewed by the PCC (i.e., once or twice annually). If at any time depression recurs, the acute phase schedule of contacts is resumed.

Figure 10: Maintenance Questionnaire

FORM TO BE COMPLETED WITH THE PATIENT WHEN
REMISSION HAS BEEN MAINTAINED FOR TWO MONTHS.
RESULTS TO BE DISCUSSED DURING STAFFING.

Pt. Name: _____ Date: _____

Date Remission Achieved: _____ Current PHQ-9: _____

How many times have you had depressive episodes like this current one in your life? _____

When was the last episode prior to this current one? _____

Dysthymia

(FOUR ANSWERS IN **BOLD*** MUST **ALL** BE CIRCLED **TO MAKE A DIAGNOSIS OF DYSTHYMIA**)

1. Have you felt sad, low or depressed most of the time for the last two years?

   NO If No, done. **YES*- continue**

2. Was this period interrupted by your feeling OK for two months or so? **NO*** YES

3. During this period of feeling depressed most of the time:

   a. Did your appetite change significantly? NO YES

   b. Did you have trouble sleeping or sleep excessively? NO YES

   c. Did you feel tired or without energy? NO YES

   d. Did you lose your self-confidence? NO YES

   e. Did you have trouble concentrating or making decisions? NO YES

   f. Do you feel hopeless? NO YES

   ARE **TWO** OR MORE **3A** TO **3F** ANSWERS CODED YES? NO **YES***

4. Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO **YES***

*ARE ALL FOUR ANSWERS IN **BOLD** CIRCLED?
IF SO, THEN CIRCLE YES. OTHERWISE, CIRCLE NO.

NO	**YES**
DYSTHYMIA CURRENT	

DATE REVIEWED IN STAFFING: _____

NOTES & RECOMMENDATIONS: _____

SECTION VII:
IMPLEMENTING THE FACILITATION PROCESS

Care Facilitator Calls to Patients

Calls to patients are typically initiated seven to 10 days following the initial office visit where the patient was diagnosed ("*index visit*") and referred to the Care Facilitator. Subsequent calls then occur every four weeks (from the date of diagnosis and/or referral) until the patient is in remission and less frequently thereafter based on staffing decisions and individual patient needs. Other calls at more frequent intervals may be warranted and are referred to here as PRN calls.

Contacts with patients in the RESPECT-Mil Three Component Model are intended to be telephonic. That does not mean that face-to-face introductions and reviews occasionally are not permissible. Face-to-face introductions are beneficial in that they may help establish an early connection between Care Facilitator and patient that will result in easier access to the patient by telephone. Conducting the four week reviews in person will be more time-consuming and will become problematic when there are a greater number of patients on the case load. It is strongly encouraged that Care Facilitators only engage in routine face-to-face follow-up when telephonic follow-up has proven unfeasible.

New Referral Activities

New referrals are initiated by PCCs through CHCS I to the Care Facilitator. Referral documentation should include the PHQ-9 and/or PCL symptom/scores, the treatment plan selected, and when the PCC would like the patient to return for a follow-up visit. Effective practice also entails the PCC's office forwarding the actual completed PHQ-9 and/or PCL to the Care Facilitator.

The Care Facilitator verifies the accuracy of PHQ-9 and PCL forms symptom count and scoring. If the forms are incorrectly scored, the Care Facilitator should notify the PCC (phone call, face-to-face, or electronic Care Facilitator report in AHLTA). Access to the baseline PHQ-9 and PCL are important to documenting the symptoms that are bothering the patient the most and monitoring change in those areas.

Record Keeping Set-Up*

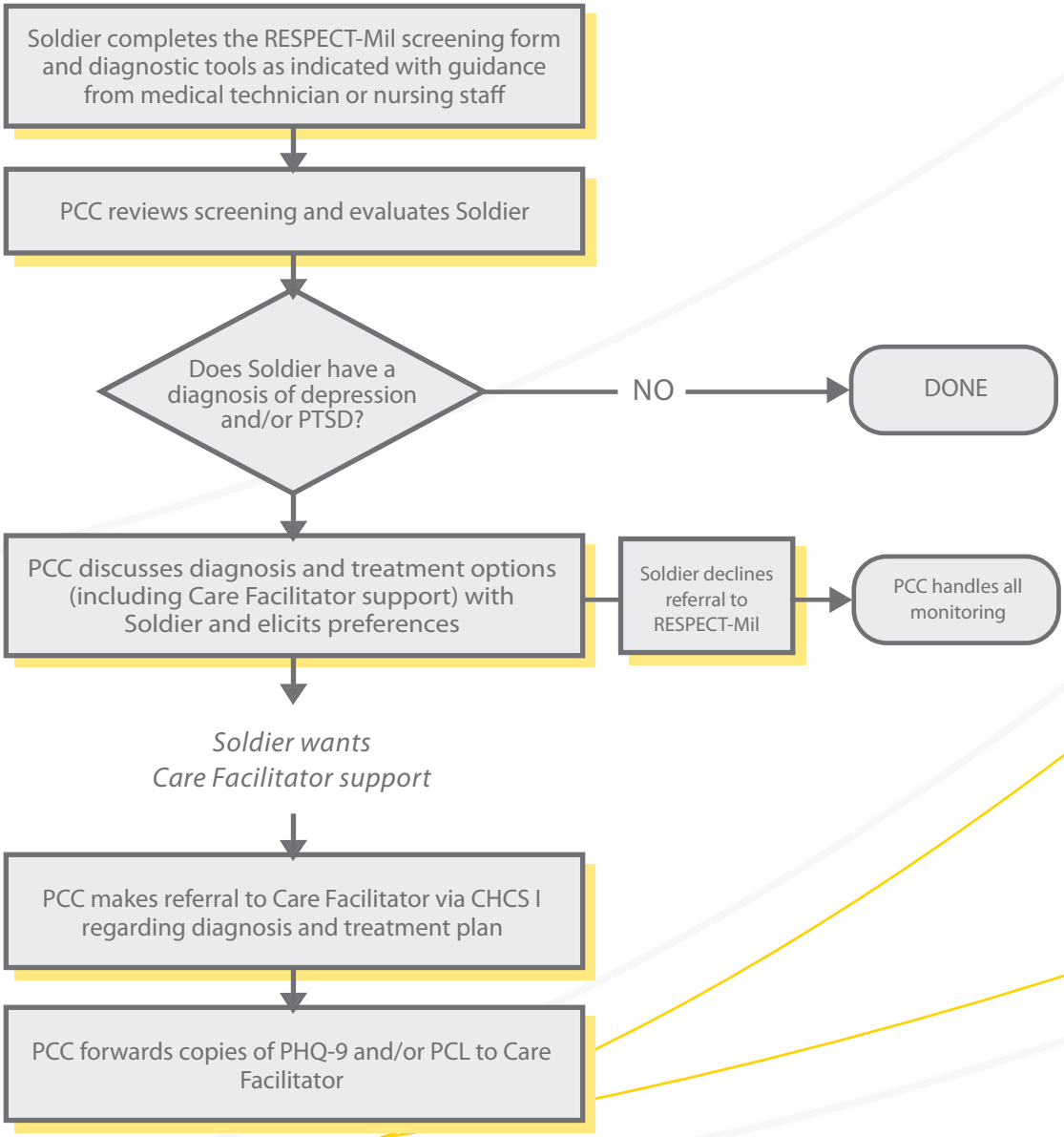
An identifying code number should be assigned for each new patient referred, and files should be created for each patient and labeled with the code number. These individual files will be used to store Care Facilitator specific anecdotal notes and documents relating to that patient. The code numbering system is important for referencing patients during staffing calls when specific patient identity is not used in order to protect confidentiality. All files and patient records will be maintained in a secure manner in accordance with the clinic/post requirements/ guidelines for HIPAA / PHI and all local, state and federal regulations.

*RESPECT-Mil will be initiating an electronic care facilitation tool (FIRST STEPS) that will automate and replace the referenced Contact Logs in this section. A separate manual will be provided for FIRST STEPS. FIRST STEPS will not replace T-Cons to PCCs through AHLTA.

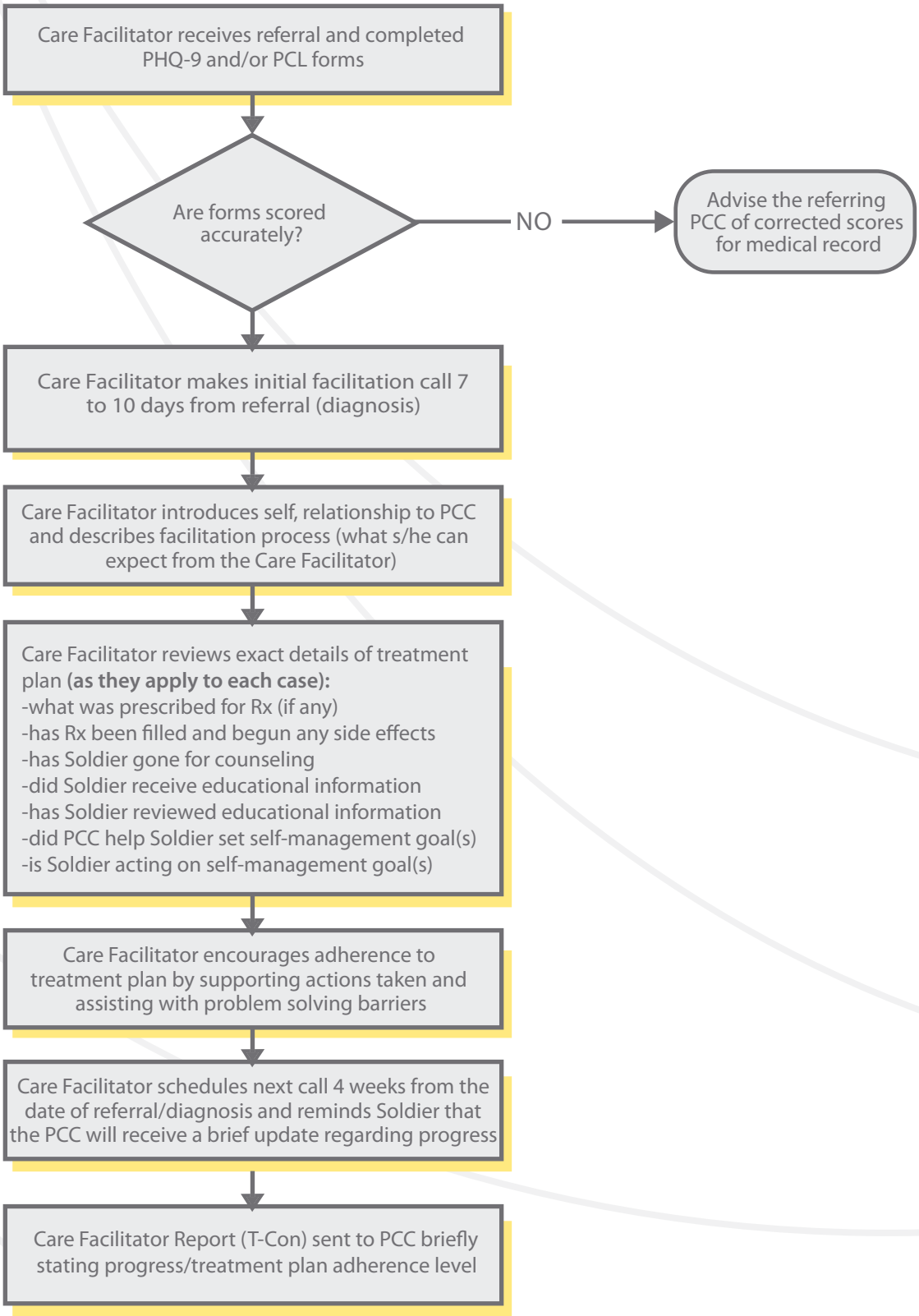
Progress Notes & Communication

Generally two types of documentation and/or forms support the RESPECT-Mil process; namely, the Care Facilitator Contact Log and the Care Facilitator Report. Most Care Facilitator Reports will be T-Cons, however a hardcopy form is available for any sites that do not have AHLTA access. Care Facilitator Contact Logs are used to both guide the call during early phases of treatment and to record anecdotal notes during each patient contact. The Contact Logs also serve as a source of data which specific sites may decide to monitor, for example, time length of calls or number of failed call attempts. The Care Facilitator Report serves to provide routine and summary information communication to the PCC following each routine contact, PRN calls with significant information obtained, and/or after weekly staffing where there is information to communicate from the BH Specialist.

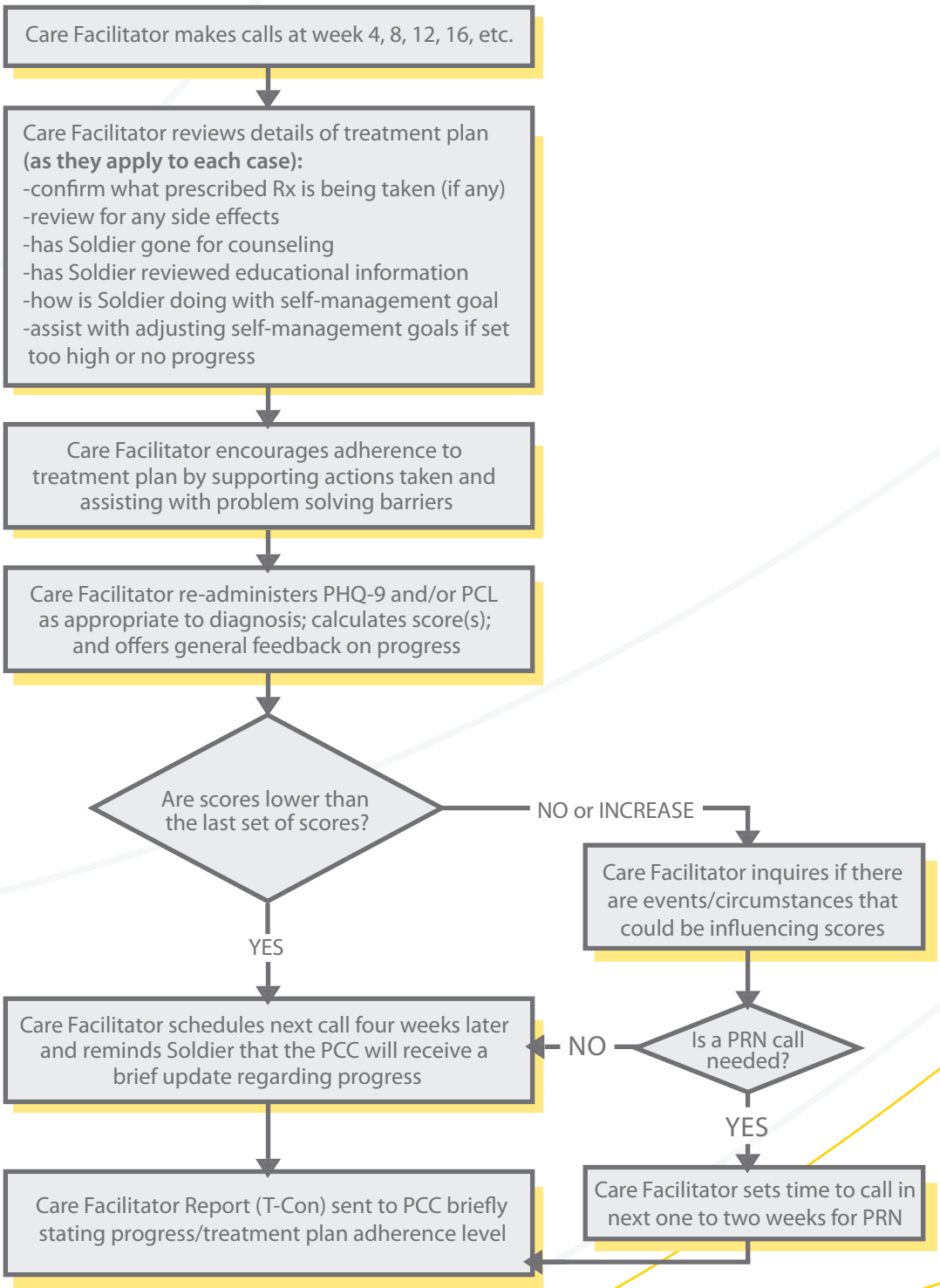
Process for Referral to RESPECT-Mil Care Facilitator



Making the Initial Care Facilitation Call



Four Week Routine Care Facilitator Calls (Scoring Calls)



SECTION VIII:
PLANNING CARE FACILITATOR CONTACTS & CONDUCTING CALLS

There are a number of useful principles for Care Facilitators who are engaged in telephonic follow-up with patients. The principles listed here will help with efficiency and workload over time.

- Maintain a balance between efficiency (staying on task with completion of the Care Facilitator documentation systems) and focusing on the needs of the patient.
- Acknowledge the patient's issues and concerns, yet focus on helping the patient drive solutions rather than extensive discussion of the details and giving direct instruction.
- Encourage that the patient define his/her own clear and attainable self-management goals.
- Offer appropriate assistance with scheduling appointments; connecting with behavioral health specialists; setting self-management goals; and problem solving to overcome barriers to treatment.

Care Facilitators are not the patient's BH Specialist or counselor and must be on guard not to slip into that role during the course of calls. **Calls should take approximately 20 minutes** unless there are unique circumstances during the call. If calls are routinely running over 30 minutes and the patient is not in crisis, then there is a need to better define boundaries for future calls/discussions. This is often a sign that the patient would benefit from behavioral health counseling and a referral should be initiated (may require PCC involvement).

Care Facilitators that engage routinely in calls of 30 minutes or more are likely providing "therapy," counseling, etc., and should evaluate how to focus calls on immediate issues of adhering to the treatment plan only.

Non-Responsive/Elusive Patients

Care Facilitators should have an understanding with the organization/practice/PCCs and the BH Specialist regarding the maximum number of "failed call attempts" they will make before referring the patient back to the PCC for follow-up. A documentable "failed call attempt" is defined as leaving a message, sending an e-mail, sending a text message, or sending a letter by mail. Busy signals, no answer, etc., are not considered documentable and call for e-mail or a letter to be sent.

A typical protocol is to make four documented attempts to reach the patient, leaving messages at each call unless the patient has requested otherwise and then advising the PCC through a Care Facilitator Report (T-Con) of inability to reach the patient.

Care Facilitators should attempt contacting the patient at **varying days and hours (including early evening) throughout the week**. There should also be a very clear limit on number of messages left, as too many messages can easily be viewed as harassing.

Calls to the Soldier's unit (with no identifying program affiliation) often produce a return call from patients. Caution must be exercised to not reveal the nature of the call and to maintain all levels of confidentiality. Care Facilitators who leave only their name and number and identification as working with the Soldier's primary care clinic have been effective.

Notations should be made in the FIRST STEPS system for each failed attempt to reach

the patient. Information to be included is the date, time, and outcome of the call (i.e., left message, talked to spouse, etc.). A friendly inquiry letter to the patient is appropriate prior to closing the patient's case in the RESPECT-Mil program. The letter should offer the patient the option to continue with the RESPECT-Mil Care Facilitation process and to verify the best phone number and times of day/week when they can be reached. The letter should also offer the patient the option to decline further contact. Care Facilitators should include a prepaid self-addressed return envelope so the patient will have less to do in order to respond. Care Facilitators should notify the PCC of this action.

If the patient does not return the letter in the time allowed (again, agree on this with the clinic and key parties – two weeks is usually a reasonable interval) or indicates they no longer wish to be contacted, then the Care Facilitator should notify the PCC immediately so that they are aware their patient no longer has Care Facilitator support. PCCs should receive copies of all letters from patients that have clear responses indicating their desire to withdraw from the RESPECT-Mil program. It is then the responsibility of the PCC to contact the patient to establish alternate care and to notify the Care Facilitator if and when the patient will return to the program.

In the case of non-responsive/elusive patients with any level of suicide risk documented via PHQ-9 or PCL questions, the Care Facilitator will document call attempts as noted above. The letter, however, will be sent via registered US Mail.

Preparation for the Call

The Care Facilitator's case load file in FIRST STEPS for the patient should be carefully reviewed prior to each call to ensure familiarity with accurate patient information (i.e., medications currently prescribed; schedule of office and/or counseling visits; established self-management goals; and any questions requiring follow-up). This review of the recent contacts as documented in FIRST STEPS is important to maintaining rapport with the patient.

Placing the Call

Care Facilitators should initially introduce themselves by indicating that s/he is working with doctor, NP or PA "X" and inquire if patient recalls being informed of the service to be provided through the RESPECT-Mil Care Facilitation process. An introduction might go something like this;

"Hello, this is (your name) and I work with Dr. X. Is this (patient's name)? Did I catch you at good time when you have a few minutes and some privacy? As you may remember, Dr. X told you that I would be calling to follow-up after your visit with him/her. Do you recall this? . . ."

Care Facilitators must be prepared to field questions about medication side effects, the depression and/or PTSD treatments prescribed (per the referral), and setting or modifying self-management goals. Inevitably, a patient will ask a question the Care Facilitator is not prepared to answer or would more appropriately be answered by their PCC. When and if this occurs **and** the issue cannot wait, patients should be advised to call their PCC or to schedule an office visit. If the question is appropriate for the Care Facilitator to respond to but the Care Facilitator needs to obtain more information, s/he should advise the patient when to expect a call back with the requested information. The Care Facilitator should note patient concerns/ questions in the Care Facilitator module in FIRST STEPS along with the plan of action.

Key Care Facilitator Discussion Points

FIRST STEPS provides a variety of modules that help guide a contact and also serve to document barriers, improvements and status changes. It is important to systematically review the details of the patient's treatment plan as prescribed by their PCC during each routine call. The initial CHCS I referral should provide a great deal of information the Care Facilitator will require to monitor treatment adherence during the initial one week call. Missing information may be obtained from the PCC's AHLTA notes.

FIRST STEPS will have a module for each of the areas outlined below.

Medications:

- Verify what medication (including dose) has been obtained by the patient (a good tip is to have the patient bring the Rx containers to the phone and read the information on the label)
- Confirm level of dosage/time of day it is being taken
- Confirm the date when medication was started; inquire about any side effects
- Identify any barriers to taking medication as prescribed
- Offer suggestions about how to counteract side effects (see page 12)

It is very important to document the date that the patient actually started taking the medication. This may well vary from the date the prescription was written. While prescription date is important, the date the patient starts the medication is more important and will provide important information as the case is staffed with the BH Specialist.

In some cases, the PCC will ask the patient to start with a half dose for a week then increase to the full dose. If this is the case, be sure the patient is complying with this plan. In the cases when this gradual approach is used, a repeat call one week after the initial call is recommended to be certain the patient has increased the medicine appropriately and no new side effects have occurred.

When the side effects are difficult for the patient, this information will often be communicated readily. When the side effects are more subtle, the patient may need prompting/questioning. Patients may not understand that what they are experiencing is a side effect and/or that it will subside or go away over time. This is an opportunity for the Care Facilitator to educate the patient about side effects or to guide the patient to contact their PCC or pharmacist (they are often able to provide specific information regarding less common side effects). Side effects that appear abnormal or extreme should be brought to the PCC's attention by the Care Facilitator as well as advising the patient to contact the clinic promptly.

Psychological Counseling:

- Verify name and type of behavioral health specialist (MD, PhD, MSW, clergy, etc.)
- Inquire whether appointment(s) has been scheduled and/or completed
- Verify the recommended frequency of visits
- Identify any barriers to participating in psychological counseling

Patients may also be involved with support groups (PTSD groups are commonly offered).

- Verify that the patient has been referred, knows the location and schedule of the group, and that the patient is attending accordingly.

Patient Education:

- Verify whether the patient has received the RESPECT-Mil patient education pamphlet(s) from their PCC (if they have not, then mail them as soon as possible)
- Verify whether patient has reviewed written materials and set goals
- Send/mail appropriate materials or resource listings (books, etc.)
- Discuss key points within the materials
- Provide information in response to patient questions or concerns

Self-Management Goals:

- Determine if self-management goals were established with PCC
- Assist patient in setting goals if none set with the PCC and/or different goals are needed that can more easily be attained
- Monitor what progress has been made
- Monitor appropriateness of current goals and likelihood of success and/or assist patient to modify goals if set too high (simple, small steps to begin with will lead to a stronger sense of accomplishment and self-management)

Obtaining Patient Responses to the Questions Contained in the PHQ-9 and/or PCL:

- Remind the patient of the form(s) s/he completed at the PCC's office.
- Start with the PHQ-9 first then complete the PCL depending on diagnoses.
- FIRST STEPS will quickly calculate the score(s) and will give the Care Facilitator the ability to gain additional information at the time if there have been increases in severity scores, a chance to give the patient general feedback and to offer encouragement that s/he is on the right track.
- If there is no change, be supportive and encourage the patient to "hang-in" with the treatment. You may need to call this patient sooner than four weeks to check on progress.
- If there is an increase in score, provide general feedback and ask if there has been anything different going on since the last scores were obtained that might indicate why they are feeling worse. This will be very helpful during staffing in making the decision whether to bump up an Rx dose or to stay the course when the increase may be situational.
- If there is any positive endorsement of the suicide question, then complete a suicide risk module immediately.

Next Primary Care Office Appointment:

- Confirm schedule of all follow-up PCC appointments for depression and/or PTSD
- Communicate importance of attending all follow-up visits
- Identify any barriers to attending follow-up visits with PCC

Case Status:

- During each contact the Care Facilitator MUST inquire if the Soldier is about to deploy in the next 90 days.
- Inquire about possibilities for Permanent Change in Station (PCS), Ending Term of Service (ETS), or other significant changes that will result in a diminishment of the patient's participation in the program.

Ending the Call

Patients should always be given a final opportunity to verbalize any concerns regarding their treatment by asking, *"Before we hang up, is there anything at all that you are concerned about regarding your treatment that you haven't already mentioned?"*

By asking this question directly, the patient is encouraged to voice things that may not have surfaced earlier in the call. Also, patients should be reminded that a brief summary of the conversation and their responses to questions in the PHQ-9 and/or PCL (if utilized during the call) will be sent to their PCC. The next Care Facilitator call should be scheduled before hanging up in hopes of decreasing failed contacts for subsequent calls.

Typical Reasons for Initiating PRN Calls

PRN calls may be required for a number of reasons and are generally initiated based on the Care Facilitator's own decision. There are also times, however, when the PCC and/or BH Specialist will request more frequent calls based on patient status. These calls are often shorter than routine calls as outlined earlier but are often of great importance for those struggling with treatment. Care Facilitators often give one or more of the following as reasons for a PRN call:

- Patient has not begun the full dose of medication; has had a change in dosage; medication has been changed; or additional medication was added.
- Concern the patient will not continue (or start) their medication due to ambivalence regarding diagnosis; presence of side effects; concern about addiction to the medication; etc.
- Patient is having difficulty with or wants to discontinue counseling; needs help getting an appointment; and/or is seeking alternatives to counseling (clergy, support groups, etc.).
- Lack of privacy for the patient or chaotic situation during scheduled call (e.g., at work, children present, etc.).
- If a suicide screen was conducted during a Care Facilitator contact and there is a need to follow-up.

Bottom line – if you feel there is a need to call again – do so.

Communication and Coordination with the PCC

A summary of each patient contact should be prepared using a Care Facilitator Report (T-Con). Only essential specific details regarding the patient's adherence to the treatment plan should be noted as well as any specific critical barriers identified. For patients with no barriers and good improvement in severity scores, these reports should be sent to the PCC at least by the end of the working day. For patients with some barriers and who need staffing in a week or less, send the T-Con **after** the staffing session along with the BH Specialist's notes so that the

PCC has only one T-Con to deal with.

Matters that appear urgent/emergent should also be conveyed by phone as soon as possible. Electronic reports should still be initiated but should not be considered the sole or primary means of communication under such circumstances.

Expectations of a Care Facilitator: A Guide for PCCs

What should a PCC Expect from a Care Facilitator?

- The Care Facilitator will call the patient at routine intervals (at 1, 4, 8, 12, 16, etc. weeks) and obtain responses to the questions contained in the PHQ-9 and/or PCL approximately at monthly intervals.
- At the request of the PCC, the BH Specialist, or at the discretion of the Care Facilitator him/herself, more frequent calls may be made.
- A Care Facilitator T-Con will be sent through AHLTA to the PCC after each routine call and after PRN calls as appropriate.
- The Care Facilitator will review newly referred patients, patients who are not responding, and problem cases with the consulting psychiatrist during weekly staffing or more frequently as needed.
- The Care Facilitator will communicate those recommendations for treatment made by the BH Specialist via T-Con, e-mail and/or phone call to the PCC and/or patient as directed by the BH Specialist (e.g., take an Rx in the AM rather than before bed). The BH Specialist may call the PCC directly to discuss treatment options.
- The PCC (or his/her covering PCC) will receive a telephone call if there is an emergency situation, e.g., when a patient is at risk for suicide.
- The Care Facilitator will provide basic patient education about depression, PTSD, medications, counseling options, and self-management goal setting.
- The Care Facilitator will facilitate adherence to all aspects of the prescribed treatment plan and report patient inability or resistance to implementation to the PCC.
- The Care Facilitator will identify barriers to implementing the treatment plan and help the patient problem solve and identify solutions.
- The Care Facilitator will make at least four attempts to locate the patient for initial calls. If, after this “good faith” effort, the patient cannot be located by phone, a letter will be sent to the patient (copy to PCC) indicating that if s/he wants to continue the facilitation process s/he should contact the Care Facilitator.
- The Care Facilitator will provide notification to PCCs of patients whose cases are closed in the RESPECT-Mil program, along with the reasons for case closure. Reasons may include transfer to specialty care, patient withdrawal from the facilitation process, failure to respond to calls for extended intervals (not due to work assignment), PCS, ETS, etc. Patients moving to another post with a RESPECT-Mil program may continue to be followed by the Care Facilitator until the case can be transferred to the gaining post.
- The Care Facilitator will assist as appropriate getting follow-up or specialty visits scheduled with PCCs, behavioral health, etc. The Care Facilitator will advise the PCC when s/he is unable to assist.

What Should a PCC NOT Expect from a Care Facilitator?

- The Care Facilitator will NOT review extensive historical, medical or psychosocial information about the patient in AHLTA. If the Care Facilitator would benefit from some specific information contained in a medical history, PCC should advise such a review.
- The Care Facilitator will NOT provide counseling or therapy. If PCC believes the patient would benefit from psychological counseling, and the patient has chosen not to accept this recommendation, the Care Facilitator will attempt to gain agreement from the patient and then facilitate a referral.
- The Care Facilitator will NOT have in-depth discussions of family difficulties, loss and grief, or other psychosocial issues. The Care Facilitator may suggest options for social support services for families.
- The Care Facilitator will NOT make home visits.
- The Care Facilitator will NOT speak separately with family members outside the presence of the patient and only at the patient's request if it is appropriate.

Sample Scripts for Telephonic Facilitation

Initial Week One Call – Barriers to Treatment

Patient has not begun taking medication for the following reason(s):

A. Not comfortable with depression diagnosis

Patient might say:

"I don't really feel depressed."

"I don't think that I am that depressed."

"I am really just stressed out."

"I just don't sleep very well so I'm tired."

Explore by asking:

"What do you think is going on?"

Intervene by:

- Explaining to the patient that their PCC believes they have depression and that treatment would be helpful.
- Explore what is uncomfortable about the diagnosis (do they know someone who is depressed or seriously mentally ill – perhaps this is frightening to them).
- Explore what they believe having depression means and attempt to dispel myths.
- If a patient continues to be adamant that s/he does not have depression, acknowledge their stance and focus more on what the symptoms are that are bothering him/her. For example, suggest that the medication s/he has been prescribed may easily help relieve their difficulty sleeping.
- If after talking further with the patient, you think that s/he is relaxing more about the diagnosis, you might mention depression and/or PTSD is a combination of the various symptoms that they are experiencing. . . difficulty sleeping, feeling helpless (areas checked on their PHQ-9). . .or. . .easily startled, feeling detached from others, avoiding certain situations/people (areas checked on their PCL).
- Inform patient his/her response "I don't really feel depressed" is fairly common and that depression is more than how one is "feeling," that is, it is the compilation of about nine different symptoms.
- Inform patient that depression quite often results from being "just stressed out," that is, it's a fairly common condition following intense or prolonged stress with estimates as high as 25 million Americans per year.

B. Not comfortable with PTSD diagnosis

Patient might say:

"I don't think that I have PTSD. I'm just a little stressed out."

"I need to be really alert – that's how you stay alive."

"I just have a lot going on and so I have bad dreams."

"I'm just jumpy because I have a hard time at my job."

Explore by asking:

"What do you think is going on?"

Intervene by:

- Explaining to the patient that their PCC believes they have PTSD and that treatment would be helpful.
- Explore what is uncomfortable about the diagnosis. Do they know someone who has PTSD or is seriously mentally ill and perhaps this is frightening to them?
- Explore whether they are fearful of military discharge if they receive treatment.
- Explore what they believe having "PTSD" means and attempt to dispel some of the myths.
- If a patient continues to be adamant that they do not have PTSD, acknowledge their stance and focus more on what symptoms they have. For example, suggest that the medication they have been prescribed may well help relieve their difficulty sleeping.
- If after talking further with the patient, you feel s/he is relaxing more about the "diagnosis," you might mention that "PTSD" is a combination of the various symptoms that they are experiencing – a sense of hyper-arousal, flashbacks, difficulty sleeping, trying to avoid certain memories, etc. (areas they checked off on the PCL).
- Again, you may normalize the conversation a bit by mentioning prevalence rates—e.g., lifetime prevalence rates for Vietnam veterans is about one out of three.

C. Not comfortable taking medication: Worried about the "stigma" of medication for "behavioral health"

Patient might say:

"I am just not a medication kind of person."

"I don't want to be on a 'depression'/'PTSD' medication."

"I wouldn't want anyone to know that I was on a medication for depression/PTSD"

"What if I have to deploy? I can't be on that sort of medication."

Explore by asking:

- *"What experiences have you had with prescribed medications in the past?"*
- *"What is your concern about being on a medication for depression/PTSD?"* (S/He may know someone who had bad side effects; have misconceptions about military discharge or action; etc.)
- Or they may be concerned about the general stigma or being judged by someone in a position of authority. *"Who do you think will judge you harshly for being on medication?"*

Intervene by:

- Helping patient explore situations when medication is or has been necessary and how they responded to the medication. What positive or negative experiences did s/he have?
- Gently reminding the patient that his/her problems and concerns have not gone away on their own and usually do not go away spontaneously for most people. Some medical assistance may be just the thing to help them get well again.

- Helping him/her understand that medication for depression/PTSD is no different than a medication for high blood pressure or diabetes (or other conditions they may mention).
- Framing the issue of taking medication as taking care of him/herself.
- Sometimes giving the "bus analogy" is helpful. Explain to him/her that they may be able to get better without medication, however, it will be a great deal more difficult and likely take longer. Use the example of a person who has a sprained ankle needing to travel from point A to point B. S/he could walk but taking the bus would be much easier and faster. In the bus analogy, once the person's ankle has healed s/he will not need the bus but for the short-term, s/he is taking advantage of the help that is available. This is true for taking prescribed medication. Medication can be a temporary help for a patient during difficult times and can give time for "healing." Eventually, the medication would not be needed anymore.
- It is also helpful to mention that some patients even find that they feel so much better on medication that they choose to remain on it indefinitely. Be ready to remind that these medications are not addictive.
- Educate patient on the biological underpinnings of depression (i.e., deficits in neurotransmitters such as serotonin) and that the medication's action is to restore these neurotransmitters to a normal level, similar to how a diabetic's medication restores his/her glucose levels to a normal level. It is not a character flaw or matter of willpower.
- Educate patient on research and clinical support for medications (i.e., results show most patients who take such medications experience significant decreases in symptom severity).
- Rehearse what a patient might tell their family about the medication that they are taking and the condition they have. Offer to send them educational materials on medication and depression/PTSD.
- Normalize with the fact that antidepressants are among the most commonly prescribed medications. About 10 million individuals in the United States take an SSRI.

D. Unclear about what medication does

Patient might say:

"I don't understand why my PCC prescribed this medication."

"I don't even know what this medication does."

Explore by asking:

"What were you told by your PCC?"

Intervene by:

- Taking the opportunity to remind patients of the seven key messages regarding antidepressants.
- Offer to send patient education information handouts. If he/she has received the handouts, ask him/her to review the information and/or go through the information together with you on the phone.
- Recommend that he/she also talk to his/her PCC at his/her next visit about the

medication and bring a list of questions he/she would like to ask.

E. Concerned about addiction

Patient might say:

"I don't want to be on medication forever."

"I don't want to get hooked or addicted to this stuff."

Explore by asking:

"Have you heard of or known someone who you believe was addicted to medication?"

Intervene by:

- Informing the patient that antidepressants are not addictive.
- Explain that it is common for people to be on a medication for six months to one year and in some cases longer. Be sure that the patient understands that the decision about how long to be on medication needs to be made with their PCC.
- Emphasize that they should not stop or change the dose of their medication(s) without FIRST talking to their PCC.
- Mention that often people go off of their medication too soon because symptoms have gone away and they are feeling better, BUT stopping too soon may cause a relapse – like stopping antibiotics too soon and having an infection return.
- A "bout" of depression and its biological underpinning (neurotransmitter deficits) often has a time course of its own, kind of like a 24 hour flu, but much longer (common duration is six to 12 months). Stopping too soon will just result in return of symptoms.

Initial Week One Call – Barriers to Treatment

Patient has not yet scheduled an appointment with a behavioral health specialist or did not keep a scheduled appointment.

A. Patient has had a negative experience with behavioral health

Patient might say:

"I have been seen before and it wasn't helpful."

"I have been seen before and I didn't like it."

Explore by asking:

"How long ago was it that you were sent to counseling?"

"Did you like the behavioral health specialist you saw?"

"How long were you in counseling?"

"Do you know specifically what it was that you didn't like about the experience?"

Intervene by:

- Encouraging the patient to explore the reasons why the prior counseling experience was not helpful. Try to determine if it was a specific counselor or behavioral health office.
- By helping a patient understand more about what he/she did not like about the

previous experience, he/she may be able to become clearer as to what he/she wants to accomplish currently.

- Consider options such as another behavioral health provider, targeted support groups (e.g., PTSD group), clinic social worker, etc.
- Some patients may prefer alternatives to behavioral health such as the chaplain.
- If they are firm in their conviction to not attend counseling, explore lifestyle (non-medical) options that can become part of their primary care treatment and complement the medical treatments they are receiving (such as a regular exercise routine, regular doses of pleasurable activities, increasing social support, receiving alternative counseling options like a chaplain, etc.).
- Explain the solid research/clinical support for certain forms of therapy for both depression and PTSD (e.g., cognitive behavioral therapy).

B. Patient has never been seen before and is nervous about what it will be like

Patient might say:

"Oh, I haven't had a chance to call for an appointment, I've been busy."

"I'm just not sure about whether I want to start counseling right now."

Explore by asking:

"Do you have any questions about what counseling is like?"

"Would you like help with scheduling an appointment?"

Intervene by:

- Educating the patient about what to expect from counseling. Send out educational materials that discuss what counseling is and what to expect.
- Certainly validate the patient's feeling of being busy (this could be very true), however, often it is an underlying nervousness or ambivalence that is behind the person delaying the scheduling of or skipping of a behavioral health appointment.
- Be ready to help with scheduling initially then transferring the responsibility to the patient.

C. Patient is worried about "stigma" of going to a behavioral health specialist

Patient might say:

"I'm not that bad off."

"I'm not that crazy."

Explore by asking:

"Do you know anyone who has gone to counseling?"

If yes. . . "What did that person tell you?"

Intervene by:

- Assure them that often it is the healthy people who seek help by going to a behavioral health specialist so that they can feel their best. It takes a lot of mental health/fitness (versus illness) to recognize getting counseling help could be beneficial.

- Collaboratively agree to a trial of counseling. Set a specific reasonable time to see if it could be helpful.
- Collaboratively agree to a stepped care approach (i.e., if patient does not respond sufficiently to primary care based treatment, then he/she will try counseling).

D. Patient is experiencing difficulty in setting up an appointment with a behavioral health provider

Patient might say:

"I left a bunch of messages at the behavioral health center and no one has gotten back to me."

"I went to behavioral health for sick call and they didn't have time for me then."

Explore by asking:

"Would you like help with scheduling your first appointment?"

Intervene by:

- Offer to help set up the first appointment. This may get the patient over the hump and onto scheduling on their own. You may run into difficulty yourself but you may also learn first hand what the patient is experiencing.
- Establish reliable contacts in the behavioral health clinic (i.e., people you know will be responsive to your needs for more effective referral).

Weeks 4, 8, 12, 16 & Beyond Calls – Barriers to Treatment

Patient is considering or has stopped taking medication without PCC input.

A. Patient has had some side effects and or concerns they may occur

Patient might say:

"I have a feeling of dryness in my mouth."

"It was making me really sick to my stomach."

Explore by asking:

"How long has this been going on?"

"How bothersome is this dryness of your mouth/nausea?"

Intervene by:

- Explaining that most side effects will subside or disappear altogether within a few weeks. If the side effect is not really bothersome, they should try to stick it out and be patient.
- Give tips on how to manage side effect symptoms, for example:
  1. Sucking on hard sugarless candy and drinking more water will often help with dry mouth.
  2. Taking medication with food will often help with nausea/stomach upset.
- If side effect symptoms are very bothersome, explain finding the right medication may take a few tries. Advise the patient to call or see their PCC to discuss alternatives that will suit them. A patient may need to try several different medications before finding the right one for them individually.

- Acknowledge that this process may be frustrating as patients just want to feel better and not feel like they are experimenting with medicines.
- Emphasize the importance of talking to their PCC about their side effects and about any decision to stop.
- If the patient has stopped taking the medication or you perceive a strong likelihood he or she will, encourage him/her to call their PCC when you conclude your call. Be sure to advise the PCC in a Care Facilitator Report regarding any discontinuation of treatment.

B. Patient is feeling better after just a short interval on medication

Patient might say:

"Oh, I'm just feeling so much better. I don't need to keep taking the medicine any longer."

Explore by asking:

"Can you describe how you are feeling now as compared to when you started the medication?"

"Are you still taking the medication and just thinking about stopping it?"

"Did your PCC indicate how long you need to take the medication?"

Intervene by:

- First, say that it is great that the medicine has helped them.
- Explain that often when people feel better they want to stop the medicine right away. But, for these medicines, it is best to remain on them for a period of time – often a number of months – even though s/he may be feeling completely better.
- The decision to stop medicine should always be made with their PCC so that s/he can guide the steps in doing so. Some medicines need to be tapered off of slowly and the PCC will decide on that.

C. Patient feels there is a lack of improvement

Patient might say:

"I don't feel any different than I did before taking the medication."

"I don't understand why things are not getting better."

Explore by asking:

"When did you expect that you would feel better?"

"What did your PCC tell you about when you should begin to feel better?"

Intervene by:

- Explain that it can take up to six weeks before patients feel the positive effect of a medication.
- If there has been improvement in the PHQ-9 and/or PCL scores, remind the patient of where improvements have occurred, e.g., sleep, agitation, etc. The patient may need reminders of improvements when questionnaires are completed only every four weeks. Help him/her acknowledge improvements and encourage him/her to hang in.
- Explore what self-management goals the patient is working on which might impact

a sense of improvement. For example, patients who are socially isolated may need prompting to help them engage in activities that will refocus their thinking and energies through positive experiences.

- Explain that benefits are often subtle and occur gradually over time and therefore may not be that noticeable. Compare and contrast their status before with now in a more focused way to see if in fact there have been no gains.
- Explain that medications are not "happy pills" and that they do not just take away negative feelings. Instead they moderate negative feelings so that they are no longer as intense and/or out of control as before.

D. Patient wants to stop counseling because it does not seem to be helping

Patient might say:

"I stopped seeing my counselor because it just doesn't seem to be helping much."

"I missed a couple of sessions and I don't think I want to go back anymore."

Explore by asking:

"What were your expectations about counseling when you began?

"What did your PCC tell you about counseling and what to expect?"

"Did you like your counselor or feel you connected during your appointments?"

"Have you tried counseling in the past?"

If yes, "What was that experience like? Was it different that this one?"

Intervene by:

- Helping the patient understand why they want to stop counseling.
- If they feel they did not connect with or did not like the individual counselor, it could be beneficial to try to schedule with another behavioral health specialist. Sometimes, it is a matter of the patient being matched with the wrong behavioral health specialist rather then the counseling itself not working.
- Use this opportunity to educate the patient about expectations for psychological counseling and send them written materials to review.

SECTION IX:
CARE FACILITATOR STAFFING AND DATA MANAGEMENT

Care Facilitator staffing sessions should be scheduled weekly and usually conducted telephonically. Access to a computer with internet connectivity is critical to the success of staffing sessions. Participants include the Care Facilitator and the specialist reviewing cases through an electronic case tracking system called FIRST STEPS. The Care Facilitator and the specialist, based on a standardized staffing agenda created for this care process, establish the format for the call. In some cases, the Care Facilitator's supervisor, primary health care leader, or RESPECT-Mil clinical leadership may be regular participants, particularly in the initial calls. It is essential that the Care Facilitator and specialist set a fixed and regular time built into their weekly schedules for these staffing sessions.

Facilitator Staffing Agenda

FIRST STEPS is developed specifically to serve the care facilitation and staffing requirements of RESPECT-Mil. The system is designed to automatically formulate the staffing agenda on demand which in turn structures the sessions/calls with the BH Specialist. This system is unique to RESPECT-Mil and provides the BH Specialist with a detailed view into each patient's case as needed to make treatment recommendations.

FIRST STEPS tracks all contacts made with patients by the Care Facilitator and documents information obtained during those contacts. It automatically calculates the PHQ-9 and PCL with change scores; tracks changes in patient status relative to medication and counseling adherence; tracks progress on self-management goals; and tracks general issues such as pending change in status (PCS, ETS, MEB, deployment, etc.).

The system 'flags' cases that need to be staffed based on the following situations:

- Any case contact when the Care Facilitator documents any level of suicidal ideation per the PHQ-9 and PCL or through interview/contact.
- No improvement in PHQ-9/PCL severity of > 5 points over four week intervals and eight weeks from the last documented treatment change.
- Cases with significant barriers to treatment adherence (e.g., side effects, waiting lists for treatment, etc.).
- Cases where the patient is about to deploy and requires a behavioral health clearance.
- Cases where remission has occurred.
- Cases needing closure – PCS, ETS, MEB, nonparticipation, etc.

While FIRST STEPS creates a staffing list automatically, the Care Facilitator must be prepared to guide the review of the cases with the BH Specialist. This means having clear notes or knowledge of the specific reasons that the case needs to be staffed during any given staffing session. This requires that the Care Facilitator preview the 'flagged' cases and organize them so that the staffing goes smoothly and as many cases are reviewed as possible. The Care Facilitator must be ready to speak about each patient listed for staffing in a concise manner, highlighting the key reasons for the staffing.

Each Care Facilitator's caseload is summarized by individual patient with graphical representations relative to improvement and level of Care Facilitator concern. The BH Specialist is able to review all contacts with any patient at any time.

The system also offers the ability to document notes from staffing that can be copied and pasted into AHLTA to satisfy the medical record tracking requirements of the clinic.

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RESPECT–Mil

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